Health, Vision, and Dental Benefit Booklet

Active and Retired Employees

July 2004

This booklet is for educational purposes only and it is not intended to serve as legal interpretation of benefits. Reasonable effort is made to have this booklet represent the intent of the plan language. However, the plan language stands alone and is not considered as supplemented or amended in any way by the explanations of examples included in this booklet.

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PART I: OVERVIEW OF IMPORTANT INFORMATION

The Medical Plan provided by the Indiana State Police as explained in this booklet is available to you and your eligible dependents as defined in Part VIII of this booklet. The benefits are available for covered expenses incurred after you are eligible as explained on page 41.

Covered services - Services or supplies for which benefits will be paid when rendered by providers, acting within the scope of their license. To be considered a covered service, charges for that service must be incurred while the enrollee's coverage under the plan is in force.

All covered services and supplies must be medically necessary. Medically necessary means that services or supplies are required for treatment of illness, injury, diseased condition or impairment and the place of treatment is appropriate for the level of care.

Covered charges: Charges for covered services to the extent in the judgment of the Contractor, (on behalf of your Employer) such charges are not excessive. The Contractor will base its judgment on professional medical opinion and upon the Reasonable Charge.

Your Deductible: Before major medical benefits are payable, you must first satisfy the Plan Deductible. The Deductible is: $150.00 per Enrollee and $300.00 per family for active Employees or retirees selecting the Optional Plan. The Deductible for retirees selecting the Basic Plan is $450.00 per Enrollee and $900.00 per family. See Page 14 for further information about your deductible.

Your Out-of-Pocket Expense: After you have satisfied your Major Medical deductible, as specified on Page 14, your plan will pay 80% of Covered Charges and you must pay the other 20% of Covered Charges, in addition to any charges which are **not covered** by the Plan. To limit your personal out-of-pocket expenses, this Plan includes a limit on your Out-of-Pocket Expense. After you have satisfied the Out-of-Pocket Limit described on Page 14, your Plan will pay 100% of Covered Charges for the remainder of that calendar year.

Plan descriptions: There are two (2) benefit plans available to active employees, the Standard Plan and the Blue Access Plan. The **Standard Plan** offers the enrollee the option of selecting any provider they wish to use without incurring a penalty. There is a higher premium associated with the Standard Plan. The **Blue Access Plan** requires the enrollee to use providers participating in the Blue Access Network. If services are received from a non network provider, you will receive a 20% penalty. This penalty does not apply in emergency situations. By using Blue Access Providers, your out of pocket expenses are reduced as well as receiving a lower payroll deduction. The deductible for active employees is $150.00 per enrollee or $300.00 per family.

There are two options available for retirees. **If you or your dependents are eligible for Medicare, the Blue Access Plan is not available.**

Basic Plan: Under the Basic Plan you may select the Standard Plan or the Blue Access Plan. When selecting the Basic Plan, benefits are not available for dental or vision. If the **Standard Plan** is selected, you may receive services from any provider without incurring any penalties. There is a higher premium associated with the Standard Plan. The **Blue Access Plan** requires the enrollee to use providers enrolled in the Blue Access Network. If services are received from a non network provider, you will receive a 20% penalty. This penalty does not apply in emergency situations. By enrolling in the Blue Access Plan, you lower your out of pocket expenses and pay a lower monthly premium.

The deductible for the Basic Plan for retirees without Medicare is $450.00 per enrollee and $900.00 per family. The deductible for retirees for the Basic Plan with Medicare is $150.00 per enrollee and $300.00 per family. The monthly premium for the Basic Plan is less than the Optional Plan premium. **If you or your dependents are eligible for Medicare, the Blue Access Plan is not available.**

Optional Plan: Benefits are available for dental or vision for retirees selecting the Optional Plan. If the **Standard Plan** is selected, you may receive services from any provider without incurring any penalties. There is a higher premium associated with the Standard Plan. The **Blue Access Plan** requires the enrollee to use providers enrolled in the Blue Access Network. If services are received from a non network provider, you will receive a 20% penalty. This penalty does not apply in emergency situations. By enrolling in the Blue Access Plan, you lower your out of pocket expenses and pay a lower monthly premium.

The deductible for the Optional Plan is $150.00 per enrollee and $300.00 per family. **If you or your dependents are eligible for Medicare, the Blue Access Plan is not available.**

Plan Maximum: The total dollar amount of benefits for which your Plan is liable. Only those benefits which are subject to the Plan Deductible apply toward the plan maximum.

The plan maximum is $1,000,000.00 per enrollee.

The total amount of major medical benefits payable for all expenses incurred for a person in his or her lifetime will not exceed the plan maximum.

However, once a person uses any portion of his or her plan maximum, on each January 1st the Plan will reinstate the used amount up to $1,000.00 to be applied to covered expenses incurred after the date of reinstatement.

Blue Access Network: If you select the Blue Access Plan, to receive full benefits, you are required to receive health care services from a provider who belongs to the Blue Access Provider Network. **If you chose the Blue Access Plan and receive services from a non network provider or out-of-state provider, you will be required to pay an additional 20% of the Covered Charges.**

Pharmacy Network: When you purchase covered drugs from an **IN-NETWORK PHARMACY,** you and your Eligible Dependents each will be required to pay $7.50 for generic formulary drugs or $12.50 for brand name formulary drugs. You will not need to file a claim if you receive services from an in-network pharmacy. You are limited to a 34 day supply or 100 units of the medication when you purchase your drugs through a retail pharmacy. When you purchase covered drugs from an **OUT-OF-NETWORK** pharmacy, **your Copayment will be subject to a 20% penalty** in addition to the $7.50 for generic formulary drugs or $12.50 for brand name formulary drugs. You are limited to a 34 day supply or 100 units of the medication when you purchase your drugs through a retail pharmacy. Contact the Indiana State Police Human Resources Division for a supply of claim forms. See Page 27 for additional information about the Pharmacy Network. DO NOT FILE PHARMACY CLAIMS WITH the Contractor. Drugs purchased that are NON-FORMULARY have a 50% Copayment.

REFER TO THE LAST PAGE OF THIS BOOKLET FOR PHONE NUMBERS YOU MAY CALL FOR MORE INFORMATION ON YOUR BENEFITS, THE BLUE ACCESS NETWORK, AND THE PHARMACY NETWORK.

PART II: DEFINITIONS

"Ambulatory Surgical Facility" means a facility that is so licensed by the state in which it operates. If that state does not issue such licenses, it means a facility with an organized staff of physicians which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;
- does not provide inpatient accommodation;
- is not, other than incidentally, a facility used as an office or clinic for the private practice of a provider individual; and
- has appropriate government planning approval, if required by its state law.

"Benefit Maximum" means the total dollar amount of benefits for which the Plan is liable under this Plan's Benefits Article.

"Blue Access Plan" means the coverage option, which requires enrollees to use providers participating in the contractor's Blue Access Network or incur a 20% penalty.

"Blue Access Network" means the Blue Access Network established by the contractor. Blue Access is a network of health care providers who have signed an Agreement with the Contractor.

"Certified Registered Nurse Anesthetist" means any individual licensed as a registered nurse by the state in which he or she practices, holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

"Clinical Laboratory" means a laboratory that performs clinical procedures and is not affiliated or associated with a hospital, physician, or other provider.

"COBRA" means Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Community Mental Health Center" means a facility which, (1) offers a program of services approved by the Indiana Department of Mental Health, or by the state in which it operates, (2) is organized for the purpose of providing multiple services for persons with mental illness, including substance abuse, and (3) is operated by one or more of the entities named in I.C. 16-16-1-1 or similar entities of the state where it is located.

"Confinement" means a period beginning on the day an enrollee enters a provider facility as a patient and ending on the day the enrollee leaves that facility or, if the enrollee was transferred from one provider facility to another, the day on which the enrollee leaves the last facility. In order for a new confinement to begin, a specified number of renewal days must elapse before the enrollee is readmitted to a provider facility.

"Contract" means all of the following: 1) this document, all Contract Schedules, Attachments, Addendum's and Riders; 2) all applications to establish and change enrollments that have been accepted by the Contractor; 3) all Identification Cards; and 4) Contract for Health Benefit Administrative Services between the State and the Contractor.

"Contract Maximum" means: the total dollar amount, as stated in this Contract's Benefits Article, for which the Plan is liable under this Contract.

"Contract Year" January 1 through December 31.

"Contractor" means the third party administrator of hospital, medical, pharmacy, dental and vision benefits provided to State.

"Copayment" means a specific dollar amount or percentage of Reasonable Charges for which the enrollee is responsible under the terms of the plan. Copayment takes effect after any deductible is met and before any stop loss limit is reached.

"Covered Charges" means charges for covered services to the extent that, in the judgment of the contractor, as authorized by the State, such charges are not excessive. The contractor will base its judgment on one or a combination of the following: a) a negotiated rate based on services provided; b) a fixed rate per day; c) the Reasonable Charge for similar providers who perform like covered services.

"Covered Services" means services or supplies specified in this plan for which benefits will be paid when provided by a provider acting within the scope of his/her/its license. In order to be considered a covered service, charges for that service must be incurred while the enrollee's coverage under this plan is in force.

"Custodial Care" means care whose primary purpose is to meet personal rather than medical needs, which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or medical condition, and which can be provided by persons with no special medical skills or training. Such care includes, but is not limited to, helping a patient walk, get in or out of bed, and take normally self-administered medicine. The Contractor, on behalf of the State, will determine, based on reasonable medical evidence, whether care is custodial.

"Day Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a provider of rehabilitation and therapeutic services for the treatment of mental illness, including substance abuse only during the day.

"Dentist" means a duly licensed dentist or physician who is performing services within the scope of his or her license.

"Dependent" – The following persons, provided coverage under the plan is in effect:

- The eligible person's spouse.
- Any of the following who qualify as the eligible person's dependent(s), until they reach the limiting age:
    1. Unmarried children;
    2. Unmarried stepchildren;
    3. Unmarried adopted children of the eligible person or spouse, from the earlier of: (a) the date of placement for the purpose of adoption; (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption; or
    4. Unmarried children for whom the eligible person or spouse has legal guardianship when both parents of the unmarried child are deceased and one of the parents of the unmarried child is a member of the enrollee's immediate family provided the unmarried child resides with the eligible person or spouse except in those cases when the child is no longer a same household resident while a full time student at an accredited educational institution.
    5. Those dependents enrolled through guardianship prior to July 1, 2000 will remain covered dependents until the earlier of:
        a. The dependent reaches the dependent limiting age: or
        b. The enrollee is no longer the legal guardian of the dependent: or
        c. The enrollee terminates coverage of the dependent for any reason. In this occurrence, any reinstatement of coverage for the dependent will be subject to the requirements of the insurance plan for the department then in effect.

- In the event a child who is a "dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the enrollee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the dependent limiting age is reached, coverage for the "dependent" will continue until the enrollee discontinues his coverage or the disability no longer exists. The department may require, at reasonable intervals, but no more often than once a year, satisfactory evidence that the disability is continuing.

"Dependent Limiting Age" is the end of the calendar year of the child's 19th birthday, or the end of the calendar year of the child's 24th birthday if the child qualifies as a federal tax exemption.

"Diagnostic Services" means the following procedures ordered by a Provider Individual, because of specific symptoms, in order to determine a definite condition or disease:

- radiology, ultrasound, and nuclear medicine;
- laboratory and pathology;
- EKG, EEG, and other electronic diagnostic medical procedures;
- psychological testing; and
- neuropsychological testing.

"Discount" means a pricing that is below retail available to Enrollees for certain services, materials, and/or supplies when utilizing a Network Provider.

"Effective Date" means coverage for employee, other than those on a direct bill basis, becomes effective on the date they elect the coverage by signing an approved payroll deduction form. Coverage for dependents takes effect when the employee becomes covered. Newborns are covered from and after the moment of birth for injuries or sickness, congenital deformities, including expenses arising from medical and dental treatment (including orthodontic and oral surgery) for birth defects known as cleft lip and cleft palate, hereditary complications, premature birth and routine nursery care. If these complications occur on a single membership, the baby is covered for thirty-one (31) days from the date of birth. Continued coverage requires election of family coverage by the thirty-first (31st) day from birth.

"Eligible Person" means a person who meets the guidelines for eligibility under the plan.

"Emergency Accident" means a sudden external event resulting in bodily injury. It does not include physical conditions resulting from sickness or disease.

"Elective Contact Lenses" means all contact lenses that are not Non-Elective Contact Lenses.

"Emergency Illness" means a medical condition that is not accident related and that is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

- Permanently placing the enrollee's health in jeopardy;
- Causing other serious medical consequences;
- Causing serious impairment of bodily function; and
- Causing serious and permanent dysfunction of any bodily organ or part.

"Enrollee" means anyone provided coverage by the express terms of this plan, whether enrolled as an eligible person or a dependent.

"Excess charges" means eligible covered services remaining after benefits for covered services have been paid under this plan's benefits articles.

"Experimental/Investigational" means:

Any drug, device, diagnostic, product, equipment, procedure, treatment, or supply (service) for which the Contractor, on behalf of the State, determines that one or more of the criteria listed below apply to the service when it is rendered for the evaluation or treatment of a disease, injury, illness or condition. The criteria must apply to the service at the time the Enrollee, receives or will receive the service, and must apply to the medical use for which benefits are sought. The service:

- cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;

- is the subject of a current drug or device application on file with the FDA;
- is provided as part of a Phase I or Phase II clinical trial, is provided as the experimental or research arm of a Phase III clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service;
- is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy among its objectives;
- is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- is provided pursuant to informed consent documents that describe the service as Experimental/Investigative, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative if the Contractor, on behalf of the State, determines that the service meets any of the four criteria below:

- the scientific evidence does not permit conclusions concerning the effect of the service on health outcomes;
- the service does not improve net health outcome by producing beneficial effects that outweigh any harmful effects;
- the service has not been shown to be as beneficial as any of the established alternative services with evidence demonstrating that the service improves net health outcome as much as, or more than, established alternatives; or
- the service has not been shown to improve net health outcomes under the usual conditions of medical practice outside clinical investigatory settings.

Documents relied upon by the Contractor to determine whether services are Experimental/Investigative based on the criteria in the above subsections may, at the Contractor's discretion, on behalf of the State, include one or more items from the following list which is not all inclusive:

- the Enrollee's medical records;
- the written protocol(s) or other document(s) pursuant to which the service has been or will be provided;
- the published, authoritative, peer-review medical or scientific literature regarding the service as it applies to the Enrollee's condition;
- any consent document(s) the Enrollee or Enrollee's representative have executed or will be asked to execute to receive the service;
- the relevant documents of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided;
- any records, regulations, applications or other documents or actions issued by, filed with, or received by the FDA, the Office of Technology Assessment, or other federal or state agencies with similar functions, that the Contractor, on behalf of the State, has in its possession at the time of the review; or
- opinions and evaluations by national medical associations or committees, consensus panels, or other technology evaluation bodies, such as the Blue Cross and Blue Shield Association's Technology Evaluation Center.

Services provided solely or primarily to support the administration of an Experimental/Investigative service, or those provided to treat anticipated or unanticipated results of an Experimental/Investigative service, will also be excluded from coverage. Services that are part of the same plan of evaluation or treatment as an Experimental/Investigative service, but which, in the opinion of the Contractor, on behalf of the State, would, in the absence of the Experimental/Investigative service be otherwise Medically Necessary, may be considered eligible for coverage, subject to all benefit requirements, limitations and exclusions.

The Contractor or its designee, on behalf of the State, has the sole authority and discretion to determine all questions pertaining to whether a service is Experimental/Investigative under this Plan.

"Family Security Benefit" means that period of time following an enrollee's death for which premiums are waived.

"First Dollar Benefits" means eligible Covered Charges which are not subject to the Plan Deductible.

"Freestanding Dialysis Facility" means a facility which is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an outpatient or home care basis.

"Home Antibiotic IV Therapy" means the administration of antibiotics intravenously, by trained personnel, in the patient's home.

"Home Health Care Agency" means an agency meeting Medicare requirements and licensed by the state(s) in which it operates to provide home health care.

"Hospital" means a facility which is a short-term, acute care general hospital and which:

- Is a duly licensed facility;
- For compensation from its patients, is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians;
- Has organized departments of medicine and major surgery; and
- Provides 24-hour nursing service by or under the supervision of RNs.

"Identification Card" means a card issued by the Contractor, on behalf of the State, that bears the Enrollee's name, identifies his or her benefit program by number, and may contain further information about his or her coverage.

"Inpatient" means an enrollee who is treated as a registered bed patient in a provider facility and for whom a room and board charge is made.

"Intermediate Care Facility" means a licensed, residential public or private substance abuse rehabilitation facility that is not a hospital and is operated primarily to provide continuous, structured 24 hour a day or partial, less than 24 hour a day, treatment and care consisting of chemotherapy, counseling, detoxification, and/or ancillary services, identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs.

"I.R.B." means Institutional Review Board.

"Lenses" means materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

"Licensed Practical Nurse" (LPN) means a person who has graduated from a formal practical nursing education program and is licensed as such by appropriate state authority.

"Medically Necessary" or "Medical Necessity" – means services or supplies received for the treatment of an illness or injury or other health condition that is determined to be:

- appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards;
- not chiefly Custodial in nature;
- not Experimental/Investigative or unproven;
- not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment, and as to institutional care, cannot be provided in any other setting, such as a Physician's office or the outpatient department of a Hospital, without adversely affecting the patient's condition; and
- not provided only as a convenience to you, your Physician or another Provider or person.

The fact that any particular Physician may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary.

"Medicare" means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician. The facility shall be:

- Licensed by the state in which it operates;
- Funded or eligible for funding under federal or state law; and/or
- Affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Mental Health Conditions (including Substance Abuse)" means a condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled "Mental Disorders".

- Mental Health is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
- Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

"Night Psychiatric Facility" means a place where patients with mental illness, including substance abuse, who are capable of remaining in the community during the day, can receive treatment at night. A Night Psychiatric Facility may be a ward or wing of a hospital or psychiatric hospital or it may be an independent facility that has been licensed or certified by the state in which it operates as a provider of psychiatric night care and assumes responsibility for coordinating care of all patients.

"Non-Elective Contact Lenses" means contact lenses which are provided for reasons that are not cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses; or
- High Ametropia-exceeding –12 D or +9 D in spherical equivalent; or
- Anisometropia-of 3 D or more; or
- Patients whose vision can be corrected three (3) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

"Occupational Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

"Out-of Pocket Limit" means the amount of Covered Charges, including the deductible, which an enrollee must pay before his or her benefits under this plan increase to 100% of Covered Charges for the remainder of the deductible period.

"Out-of-Pocket Limit Exception" Covered charges for the following do not accrue to the out-of-pocket limit and benefits for them do not increase to 100% of Covered Charges when the out-of-pocket limit is reached:

- Dental
- Vision

- Prescription drug Copayments

"Outpatient" means an enrollee who is a patient, other than a bed patient, at a provider facility.

"Outpatient Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a provider of rehabilitation and therapeutic services for the treatment of mental illness, including substance abuse, on an outpatient basis.

"Partial Hospitalization" means a psychiatric service offered in a hospital or in a psychiatric treatment center or in a community mental health center providing medically directed intensive or intermediate short-term psychiatric treatment for a period of less than 24 hours but more than 4 hours a day for any individual patient.

"Pharmacy" means any facility so licensed by the state in which it operates.

"Physical Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, a person certified as such by an appropriate professional body.

"Physician" means a doctor of medicine, a doctor of osteopathy, a psychologist, a chiropractor or any other practitioner of the healing arts who is licensed by the appropriate agency and is practicing within the scope of that license.

"Plan" means all of the following:

- This document, all Contract Schedules, Attachments, Addendums and Riders;
- All applications to establish and change enrollments that have been accepted by the Contractor;
- All Identification Cards; and
- Contract for Health Benefit Administrative Services between the Indiana State Police and the Contractor.

"Plan Deductible" means a specified amount of covered services, usually expressed in dollars, that must be incurred by an enrollee before the plan will assume any liability for all or part of the remaining covered services. If two or more persons covered by the same coverage, are injured in the same accident, only a single deductible will be applied to all Covered Charges that are accident related.

"Plan Description" means all of the following:

- This document, and all Plan Schedules and Riders;
- All applications to establish and change Plan Enrollments that have been accepted by the Contractor on behalf of the State;
- All Identification Cards.

"Plan Enrollment" means an eligible person's or dependent's right to this plan's benefits subject to its exclusions, limitations, and conditions.

"Plan Maximum" means the total dollar amount of benefits for which the plan is liable under this Plan's Benefits Article.

"State" means the legal entity contracting with the contractor for the administration of dental, vision, pharmacy, and health care benefits.

"Plan Year" means the 12 month period beginning each January 1.

"Provider Facility" means Ambulatory Surgical Facility, Hospital, Day/Night Psychiatric Facility, Freestanding Dialysis Facility, Outpatient Psychiatric Facility, Rehabilitation Facility, Residential Short-term Detoxification Facility, and Substance Abuse Facility.

"Provider Individual" means Certified Registered Nurse Anesthetist, Licensed Practical Nurse (LPN), Occupational Therapist, Physical Therapist, or Physician.

"Psychiatric Hospital" means a facility licensed by the state in which it operates to provide diagnostic and therapeutic services for treatment of mental illness, including substance abuse, on an inpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness and substance abuse, if such services are provided by or under the supervision of an organized staff of physicians and if continuous nursing services are provided by RNs.

"Psychologist" means a person certified by the Indiana State Board of Examiners in Psychology or, outside the State of Indiana, one who is licensed or certified as such by the state in which he or she practices. Where there is no state licensure or certification, the Psychologist must be certified by an appropriate professional body.

"Reasonable Charge" means the maximum amount that is determined to be reasonable for Covered Services you receive, up to but not to exceed charges actually billed. This determination considers:

- amounts charged by other Providers for the same or similar service;
- any unusual medical circumstances requiring additional time, skill or experience;
- other factors determined as relevant, including but not limited to, a resource based relative value scale; and
- the amount accepted by a Network Provider as payment in full under the participation agreement for this Plan.

For a Network Provider, the Reasonable Charge is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the maximum Reasonable Charge.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Administrator for another product, the Reasonable Charge is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.
For a Provider who has a participation agreement with the Administrator, the Reasonable Charge is equal to the amount that constitutes payment in full under any participation agreement with the Administrator. If a Provider accepts as full payment an amount less than the negotiated rate under a participation agreement, the lesser amount will be the maximum Reasonable Charge.

"Recovery" means money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

"Registered Nurse" (RN) means a person who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed as such by appropriate state authority.

"Rehabilitation Facility" means a facility licensed by the state in which it operates to provide rehabilitative care on an inpatient or outpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing medical, social, educational, and vocational services to enable patients, when the services are medically necessary, to achieve the highest possible level of functional ability. Services must be provided by or under the supervision of an organized staff of physicians and continuous nursing services must be provided under the supervision of registered nurses.

"Residential Short Term Detoxification Facility" means a facility licensed or certified by the state in which it operates to provide 24-hour supervision in a structured therapeutic environment for the treatment and resocialization of substance abuse patients.

"Respiratory Inhalation Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

"Semi-private room" means the charge made by a hospital for a room containing two beds.

"Speech Pathologist" or "Speech Therapist" means a person so licensed by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as a Speech Pathologist or Speech Therapist by an appropriate professional body.

"Skilled Care" means: (1) the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury; and (2) must be performed by or under the supervision of licensed health care personnel.

"Spouse" means the person recognized as the eligible person's husband or wife under the laws of the state where the eligible person lives.

"State" means the Indiana State Police Department.

"Standard Plan" means the coverage option, which allows the enrollee to select any provider they wish to use without incurring a penalty; however, payments are subject to the covered charges allowance.

"Substance Abuse" means a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

"Substance Abuse Facility" means a facility licensed or certified by the state in which it operates as a provider of detoxification and/or rehabilitation treatment for substance abuse patients.

PART III: HEALTH CARE MANAGEMENT

NOTE: The following section applies only to Enrollees who have selected the Blue Access Plan.

Health Care Management is included in the Enrollee's health care benefits to encourage the Enrollee to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Enrollees by assuring the use of appropriate procedures, setting (place of service), and resources using Precertification, Concurrent Review, and Case Management.

For each Health Care Management feature, the purpose of the feature, what is required, and effects on benefits are explained.

PRECERTIFICATION

NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed.

Precertification is a procedure which requires that an approval be obtained from the Plan before incurring expenses for certain Covered Services. When care is evaluated, both Medical Necessity and appropriate length of stay will be determined. For certain services the Enrollee will be required to use the Provider designated by the Contractor's Health Care Management staff, on behalf of the State. Medical Necessity includes a review of both the service and the setting. When approved, a copy of the approval will be provided to the Enrollee, the Physician, and the Hospital or facility. The care will be covered according to the Enrollee's benefits for the number of days approved unless the Contractor's Concurrent Review, on behalf of the State, determines that the number of days should be revised. Most Providers know which services require Precertification and will obtain any required Precertification. The Enrollee's Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. If the Enrollee uses a Non-Network Provider, the Enrollee will be responsible for any services which are not Medically Necessary. If a request is denied, the Provider may request a reconsideration to be completed within 3 days of the request. An expedited reconsideration may be requested when the Enrollee's health requires an earlier decision.

The Enrollee is requested to obtain Precertification for certain services obtained from a Non-Network Provider; or, if the Enrollee is traveling or lives outside of the Service Area and has used the BlueCard program to obtain a Network or Participating Provider through the local Blue Cross and Blue Shield Plan.

When the Enrollee is requested to obtain Precertification, the Enrollee should verify that the Non-Network Provider obtains the requested Precertification or the Enrollee should obtain the requested Precertification. If the Enrollee does not obtain any requested Precertification, the Enrollee is responsible for all charges for services the Contractor determines are not Medically Necessary. If the Enrollee fails to obtain Precertification, a retrospective review will be done to determine if the Enrollee's care was Medically Necessary.

If the Enrollee has any questions regarding Health Care Management or to determine which services require Precertification, the Enrollee should call the telephone number on the back of the Identification Card.

For Emergency admissions, Precertification is not required. However, the Enrollee is requested to notify the Contractor and/or the Plan or the Enrollee's Physician of the admission within 48 hours or as soon as possible within a reasonable period or services after 48 hours could be denied.

CONCURRENT REVIEW

Concurrent Review is a process in which nurses monitor the Enrollee's progress during an Inpatient admission. As a result of Concurrent Review, additional days of Inpatient care may be approved which exceed the number originally authorized by the Contractor's Health Care Management staff, on behalf of the State. With prior notice from the Contractor, on behalf of the State, the number of days originally authorized through Precertification may be reduced when it is determined that continued Inpatient care is no longer Medically Necessary.

For concurrent review, the determination should be made within one business day after all information is provided and notice of the decision is required within one business day after the determination.

CASE MANAGEMENT (INCLUDES DISCHARGE PLANNING)

Case Management is a feature designed to assure that the Enrollee's care is provided in the most appropriate and cost effective care setting. This feature allows the Plan to customize the Enrollee's benefits by approving otherwise non-covered services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Contractor's Health Care Management staff, on behalf of the State. In managing the Enrollee's care, the Plan has the right to authorize substitution of Outpatient Services or services in the Enrollee's home to the extent that benefits are still available for Inpatient Services.

PART IV: BENEFITS

Subject to the exclusions, limitations, and conditions of this plan, an enrollee is entitled to the following benefits when services are both medically necessary and provided by a provider facility or provider individual, as defined in Article I. This health coverage includes two benefit plans: the Standard Plan and the Blue Access Plan. If an enrollee selects the Blue Access Plan, the enrollee is required to receive services from a health care provider who belongs to a Blue Access Network to receive full plan benefits. If the enrollee receives services from a provider who is not a member of a Blue Access Network, the benefits will be reduced by 20%. This penalty does accrue toward the maximum out-of-pocket limit. This reduction will not occur in case of emergency treatment, or if services are rendered by exempt providers. If the enrollee is a retiree, eligible for Medicare, the Blue Access Plan does not apply.

If the enrollee selects the Standard Plan, the enrollee will receive full plan benefits regardless of whether the provider belongs to a Blue Access Network.

DEDUCTIBLE

The Plan Deductible is:

Active Employees and Retirees Optional Benefit Plan

$150.00 per enrollee

$300.00 per family for all active employees and retirees who are eligible for Medicare and who selects the optional benefit plan.

Basic Benefit Plan-Retirees Not Eligible for Medicare

For retirees who are not eligible for Medicare and who select the basic benefit plan the deductible is:

$450.00 per enrollee or $900.00 per family.

Basic Benefit Plan-Retirees Eligible for Medicare

For all retirees who are eligible for Medicare the deductible is:

$150.00 per enrollee or $300.00 per family.

The Deductible Period is:

January 1 through December 31.

Deductible Carryover:

Any amounts applied to the deductible for covered expenses incurred during the last three months of the deductible period will also be applied to meet the next year's deductible.

This provision applies to Major Medical benefits only.

OUT OF POCKET EXPENSE LIMIT

The Out of Pocket Expense Limit per calendar year is:

$500.00 per Enrollee in addition to the calendar year deductible.

$1,000.00 per Family in addition to the calendar year deductible.

Charges for dental, vision, and prescription drug Copayments do not apply to the out of pocket expense limit and benefits for them do not increase to 100% when the out of pocket expense limit is reached.

This provision applies to Major Medical benefits only.

NOTE: The out of pocket expense limit applies only to enrollees who are active employees or retirees who have selected the optional benefit plan. Benefits for retirees covered under the basic plan do not increase to 100%.

PLAN MAXIMUM

The plan maximum is $1,000,000.00 per enrollee.

BLUE ACCESS PROVIDER INCENTIVE

If an enrollee selected the Blue Access Plan, the enrollee is required to receive services from a health care provider who belongs to a Blue Access Network. If an enrollee receives services from a provider who is not an enrollee of a Blue Access Network, the benefits will be reduced by 20%. This penalty does accrue toward the maximum out-of-pocket limit. This reduction will not occur in the case of emergency treatment or if the enrollee receives services from an exempt provider. If the enrollee is a retiree and eligible for Medicare, the Blue Access Plan does not apply.

HOSPITAL INPATIENT

Benefits paid for hospital room and board are:

Semi-private room:

100% of Covered Charges.

Private room:

100% of Covered Charges when use is medically necessary or when the hospital has private rooms only.

Specialty care units such as intensive care, cardiac, and burn units: 100% of Covered Charges.

NOTE: If the Enrollee chooses a private room instead of a semi-private room, the Enrollee will be responsible for the difference in cost between the private room rate and the semi-private room rate.

Benefits paid for hospital ancillaries, including diagnostic services are:

100% of Covered Charges.

MENTAL ILLNESS (OUTPATIENT)

Covered services include electroshock therapy when administered by a physician, anesthesia for electroshock therapy; psychological testing when administered by an employee of a covered psychiatric facility; counseling for others in the eligible person's family.

Benefits for mental illness are the same as any other condition exception for the following:

Benefits paid for mental illness outpatient services at a provider facility are:

Subject to the plan deductible.

80% of Covered Charges.

Benefits paid for outpatient mental illness provider individual services are:

Subject to the plan deductible.

80% of Covered Charges.

HOSPITAL INPATIENT (MENTAL ILLNESS)

Benefits paid for hospital room and board are:

Semi-private room:

100% of Covered Charges.

Day limits per enrollee are:

365 days per confinement with 90 days per renewal.

Covered charges in excess of this benefit are paid at 80% of Covered Charges under the Major Medical benefit.

Benefits paid for hospital ancillaries, including diagnostic services are:

100% of Covered Charges.

SUBSTANCE ABUSE (OUTPATIENT)

Covered services include electroshock therapy when administered by a physician, anesthesia for electroshock therapy; psychological testing when administered by an employee of a covered psychiatric facility; counseling for others in the eligible person's family, to allow 20 visits per occurrence with a limit of two occurrences per lifetime.

Benefits for substance abuse are the same as any other condition exception for the following:

Benefits paid for substance abuse outpatient services at a provider facility are:

Subject to the plan deductible.

80% of Covered Charges.

Benefits paid for outpatient substance abuse provider individual services are:

Subject to the plan deductible.

80% of Covered Charges.

HOSPITAL INPATIENT (SUBSTANCE ABUSE)

Day limits for substance abuse per enrollee are:

60 days per admission.

Lifetime maximum for substance abuse are:

2 admissions.

100% of Covered Charges.

INPATIENT MEDICAL VISITS

Benefits paid for inpatient medical visits in a provider facility are:

100% of Covered Charges.

NOTE: This plan covers one visit per physician, each day, for separate diagnosis. Covered services do not include inpatient medical visits during surgery admissions, unless the visit is for a diagnosis that is different from the surgery diagnosis.

INTENSIVE MEDICAL CARE

Benefits paid for intensive medical care are:

100% of Covered Charges.

CONSULTATIONS

Benefits paid for inpatient consultations in a provider facility are:

100% of Covered Charges.

Maximum per enrollee:

One consultation per condition per day.

Benefits paid for outpatient and office consultations are:

Subject to a $15.00 Copayment per visit.

SURGERY

Surgical service also includes diagnostic services and therapy services directly related to the covered surgery.

Benefits paid for surgery in a provider facility and physician's office are:

100% of Covered Charges.

Benefits paid for a physician's services done in conjunction with surgery are:

100% of Covered Charges.

Benefits paid for an assistant surgeon's surgery services are:

100% of Covered Charges. Covered charges for assistant surgeons are not to exceed 20% of the total surgical allowance.

Additional covered services: extraction of partially or fully impacted teeth in an outpatient setting, including a physician's office.

Limits: When two or more operations are performed through the same surgical approach, Payment shall be made only for the operation for which the higher cost is charged.

When two or more distinct surgical procedures are performed in different operative fields during one operation period, the maximum payment shall be that specified for the major surgical procedure plus one-half of the respective allowance for each of the other surgical procedures:

No additional fee will be paid for a secondary operation or procedure following the primary operation, such as reopening the incision for exploration, removal of hematoma, control of bleeding, resuturing, and similar services connected with the original service.

Incidental surgical procedures will not be covered by the Contractor.

Reconstructive Breast Surgery

Covered services for reconstructive surgery following mastectomies are: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Benefits paid for reconstructive breast surgery are:

100% of Covered Charges.

Mastectomy Notice

An Enrollee who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual Deductible and Copayment provisions otherwise applicable under the Plan.

MORBID OBESITY

Covered services include surgical treatment by a Provider of morbid obesity:

- that has persisted for at least (5) years;
- and for which nonsurgical treatment that is supervised by a Physician has been unsuccessful for at least (18) consecutive months.

"Morbid obesity" means:

- A weight of at least two (2) times the ideal weight for frame, age, height, and gender has specified in the 1983 Metropolitan tables;
- A body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- A body mass index of least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

Benefits paid for Morbid Obesity are:

100% of Covered Charges.

Limit: one procedure per lifetime.

ANESTHESIA

Covered Services are general and regional anesthesia when it is medically necessary that the service be performed by a provider individual other than the surgeon or assistant surgeon or obstetrician.

Benefits paid for anesthesia are:

100% of Covered Charges.

HUMAN ORGAN TRANSPLANT

Covered human organ transplant procedures are: Bone Marrow, Heart, Heart/Lung, Lung, Liver, Pancreas, Kidney/Pancreas, Kidney, and Cornea transplants.

Benefits paid for transplant services are:

100% of Covered Charges.

NOTE: No additional transplant procedures are covered services under this Plan.

ELECTIVE SECOND AND/OR THIRD SURGICAL OPINION

When a physician recommends surgery, payment will be provided upon request for a second surgical opinion rendered by another physician. If the second physician does not recommend surgery, the opinion of a third physician will be eligible upon request. The physician recommending surgery and the consulting physician cannot be in practice together. Diagnostic tests done in conjunction with providing an opinion are also covered and do not accrue to any diagnostic maximums.

Benefits paid for elective second surgical opinions are:

100% of Covered Charges.

DENTAL CARE

Covered services; Inpatient and outpatient hospital fees and physician services for extraction of teeth or for other dental processes, when inpatient hospital confinement and/or outpatient hospital treatment are medically necessary and documented by the attending physician.

Benefits paid for dental care are:

Same as for any other condition.

DIAGNOSTIC SERVICES

The following procedures are covered when ordered by a provider individual because of specific symptoms:

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Psychological testing; and
- Neuropsychological testing.

Benefits paid for diagnostic services in a provider facility are:

100% of Covered Charges.

Benefits paid for diagnostic services provided by a physician are:

100% of Covered Charges.

EXCEPTIONS: Unless otherwise provided, your benefits do not include the following services:
- Audiometric testing (when performed to determine the necessity of a hearing aid);
- Eye refractions;
- Examinations for fitting of eye glasses, contact lenses or hearing aids, dental examinations; and
- Research studies, screening examinations, physical examinations or checkups.

SCREENING MAMMOGRAPHIC SERVICES

Screening mammograms and related office visits are covered for eligible enrollees and eligible dependents. The maximum number of screening mammograms and related office visits payable under this plan is one (1) per enrollee or dependent per calendar year.

Benefits paid for screening mammographic services are:

100% of Covered Charges.

SCREENING BREAST ULTRASOUNDS

Screening breast ultrasounds and related office visits are covered for eligible enrollees and eligible dependents. The maximum number of screening breast ultrasounds and related office visits payable under this plan is one (1) per enrollee or dependent per calendar year.

Benefits paid for screening breast ultrasounds are:

100% of Covered Charges.

SCREENING PAP SMEARS

Pap smears and related office visits are covered for eligible female enrollees and eligible female dependents. The maximum number of pap smears and related office visits payable under this plan is one (1) per female enrollee or female dependent per calendar year.

Benefits paid for screening pap smears are:

100% of Covered Charges.

SCREENING PSA TESTING

Screening PSA tests and related office visits are covered for male enrollees and eligible male dependents. The maximum number of screening PSA tests and related office visits payable under this plan is one (1) per male enrollee or male dependent per calendar year.

Benefits paid for screening PSA testing are:

100% of Covered Charges.

SCREENING COLORECTAL CANCER EXAMINATION

Screening colorectal cancer examination and related laboratory test and office visits are covered for eligible enrollees and eligible dependents. The maximum number of screening colorectal cancer examination and related laboratory tests and office visits payable under this Plan is one (1) per enrollee or dependent per calendar year.

Benefits paid for screening colorectal cancer examinations are:

100% of Covered Charges.

PREADMISSION TESTING

Covered services are necessary tests and studies performed in an outpatient setting before an inpatient hospital admission.

Services are not covered if:

- performed to establish a diagnosis;
- repeated after admission to the hospital;
- performed more than seventy-two (72) hours before date of admission; and/or
- if the admission is canceled or postponed.

Benefits paid for outpatient preadmission testing in a provider facility are:

100% of Covered Charges.

EMERGENCY ILLNESS

Emergency illness is not accident related and is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

- Permanently placing the enrollee's health in jeopardy;
- Causing other serious medical consequences;
- Causing serious impairment of bodily function; and
- Causing serious and permanent dysfunction of any bodily organ or part.

Benefits paid for emergency illness services provided in a provider facility outpatient setting are:

100% of Covered Charges.

Benefits paid for emergency illness services provided by a physician are:

100% of Covered Charges.

Limit: Treatment must be received within 72 hours of the onset of the illness to be covered under this benefit.

EMERGENCY ACCIDENT

Benefits paid for emergency accident services provided in a provider facility outpatient setting are:

100% of Covered Charges.

Benefits paid for emergency accident services provided by a physician are:

100% of Covered Charges.

Limit: Treatment must be received within 72 hours of the accident in order for charges to be covered under this benefit.

AMBULANCE

The service must be provided by a hospital or a government certified ambulance service in a vehicle designed and equipped to transport the sick and injured. Both air and ground ambulance services are included in this benefit.

Benefits paid for ambulance are:

100% of Covered Charges for a ground or air trip when medically necessary.

THERAPY SERVICES

Therapy services means the following services and supplies ordered by a provider individual used for the treatment of an illness or injury to promote the recovery of the enrollee or eligible dependent.

Radiation therapy which is the treatment of disease by x-ray, radium, or radioactive isotopes.

Benefits paid for radiation therapy services provided by a provider facility and/or a provider individual are:

100% of Covered Charges.

Chemotherapy which is the treatment of disease by chemical or biological antineoplastic agents.

Benefits paid for chemotherapy provided by a provider facility and/or a provider individual are:

100% of Covered Charges.

Additional covered service -- the first hairpiece or wig required as a direct result of hair loss due to chemotherapy or radiation therapy.

Limit: 100% of the Reasonable Charge for the first hairpiece or wig, up to a plan maximum of $175.00 per enrollee.

Dialysis Treatments which are the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body; includes hemodialysis or peritoneal dialysis.

Benefits paid for dialysis treatments provided by a provider facility and/or a provider individual in an outpatient (including the provider individual's office) setting are:

100% of Covered Charges.

Physical Therapy is the medically necessary treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical, acupuncture, and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

Benefits paid for physical therapy provided in a provider facility outpatient and/or provider individual including the provider individual's office are:

Subject to a $15.00 Copayment per visit.

Respiratory/Inhalation Therapy is the introduction of dry or moist gases into the lungs for treatment purposes.

Benefits paid for respiratory/inhalation therapy provided in a provider facility outpatient setting and by a provider individual are:

Subject to a $15.00 Copayment per visit.

Occupational Therapy is treatment designed to improve muscle strength, joint motion, coordination and endurance of a physically disabled person, when given by a physical therapist or an occupational therapist.

Benefits paid for occupational therapy provided in a provider facility in an outpatient setting, and/or provider individual including the provider individual's office are:

Subject to a $15.00 Copayment per visit.

Speech Therapy which is the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous therapeutic processes.

Benefits paid for speech therapy provided in a provider facility and/or provider individual outpatient setting including the provider individual’s office are:

Subject to a $15.00 Copayment per visit.

Limit: Speech therapy is a covered item only when received as a result of a congenital anomaly or following an accident, stroke, surgery or disease.

MATERNITY

Benefits paid for Maternity are:

Same as any other condition.

Coverage for the Inpatient postpartum stay for the Enrollee and the newborn child in a Hospital will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Enrollee's attending Physician determines further Inpatient postpartum care is not necessary for the Enrollee or the Enrollee's newborn child, provided the following are met:

- In the opinion of the Enrollee's attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

    1. the antepartum, intrapartum, and postpartum course of the mother and infant;
    2. the gestational stage, birth weight, and clinical condition of the infant;
    3. the demonstrated ability of the mother to care for the infant after discharge; and
    4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.

- **One (1) at-home post delivery care visit** is provided to the Enrollee at the Enrollee's residence by a Physician or Nurse performed no later than forty-eight (48) hours following the Enrollee's and newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

    1. parent education;
    2. assistance and training in breast or bottle feeding; and
    3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Enrollee or the newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

    At the Enrollee's discretion, this visit may occur at the Physician's office.

Coverage for the Inpatient postpartum stay for the Enrollee and the newborn child in a Hospital will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. In addition, coverage is provided for an examination given at the earliest feasible time to the Enrollee's newborn child for the detection of the following disorders:

- Phenylketonuria;
- Hypothyroisism;
- Hemoglobinopathies, including sickle cell anemia;
- Galactosemia;
- Maple Syrup urine disease;
- Homocystinuria;
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
- Physiologic hearing screening examination for the detection of hearing impairments;
- Congenital adrenal hyperplasia;
- Biotinidase deficiency;
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Initial Newborn Care

Covered services include the initial routine newborn examination following delivery when performed in a hospital by a physician except the delivering physician. Subsequent routine visits are covered by a physician to the newborn until the newborn is released from the hospital.

Benefits paid for routine newborn care are:

100% of Covered Charges.

Benefits payable for dependent children are also payable for a sick or injured newborn infant of a enrollee for the first 31 days of his or her life on a single policy. The coverage for the newborn infant consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Coverage includes, but is not limited, to, benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in managing birth defects known as cleft lip and cleft palate.

Newborn Infant Coverage

The benefits payable for eligible Dependent children shall be paid for a sick or injured newborn infant of an Eligible Person for the first 31 days of his or her life. The coverage for newly adopted children will be the same as for other Eligible Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:
   a. The date of placement for the purpose of adoption; or
   b. The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;
2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is taken.

Single Policy

To be covered beyond the first 31 days on a single policy, the newborn must be added to the enrollee's plan membership. The enrollee will need to contact the Human Resources Division to obtain the appropriate enrollment forms. The enrollee will be liable for the higher premium for the entire pay period in which the child was added.

Family Policy

The Contractor will automatically add a newborn child to an existing family membership. The Contractor will send a notice to the enrollee that an enrollment form must be completed with the child's name. The enrollee will need to contact the Human Resources Division to obtain the enrollment form.

NOTE: THIS PROCEDURE DOES NOT APPLY IN CASES OF:

- **ADOPTION**
- **MARRIAGE**
- **DIVORCE**
- **GUARDIANSHIP**
- **CHANGE IN DEPENDENT STATUS**

IN THESE CASES, YOU MUST CONTACT THE HUMAN RESOURCES DIVISION TO OBTAIN THE APPROPRIATE ENROLLMENT FORMS.

ACCIDENTAL DENTAL

Benefits paid for treatment of dental conditions caused by an accidental injury occurring after the enrollee's effective date are:

100% of Covered Charges if treatment is received within six (6) months after the accident.

OFFICE CALLS

Benefits paid for office calls are:

Subject to a $15.00 Copayment per visit.

EXCEPTION: see mental illness and substance abuse benefits.

Routine Exams and Periodic Physicals

Covered services are routine or periodic exams based on the Enrollee's age, sex and health status as determined by the Enrollee's physician. The maximum number of routine exams, periodic physicals and related office visits payable under this Plan is one (1) per Enrollee or Dependent over age 1 per calendar year.

Benefits paid for annual routine exams and periodic physicals are:

Subject to a $15.00 office visit Copayment per visit.

100% of Covered Charges.

EXCEPTIONS: Not covered are physical exams required for:

- enrollment in any insurance program;
- as a condition of employment; or
- for licensing.

Immunizations

Covered services include pediatric immunizations in accordance with accepted medical practice, and adult immunizations when Medically Necessary.

Benefits paid for immunizations are:

Subject to a $15.00 office visit Copayment per visit.

100% of Covered Charges.

EXCEPTIONS: Not covered are immunizations required for:

- enrollment in any insurance program;
- as a condition of employment; or
- for licensing.

Other Routine Diagnostic Services

Covered services are laboratory and pathology services, radiology, ultrasound, EKGs, EEGs, and other electronic diagnostic medical tests, and Magnetic Resonance Imaging (MRI). The maximum number of routine diagnostic services and related office visits payable under this Plan is one (1) per Enrollee or Dependent per calendar year.

Benefits paid for appropriate diagnostic services are:

Subject to a $15.00 office visit Copayment per visit.

100% of Covered Charges.

NOTE: Other routine Diagnostic Services are covered as determined appropriate for your age or sex when performed on an asymptomatic patient as preventive care. If you have questions about wheather a diagnostic test is appropriate for your age or sex please contact customer service.

Well Baby Care Services

Covered services are periodic examinations based on the Enrollee's age and health status as determined by the Enrollee's physician, up to age one (1).

Benefits paid for well baby care services are:

Subject to a $15.00 office visit Copayment per visit.

100% of Covered Charges.

Attention Deficit Disorder

Covered services are inpatient or outpatient for Attention Deficit Disorder and learning disabilities which, in the judgement of the Contractor's medical consultants, on behalf of the State, are medically necessary.

Benefits paid for Attention Deficit Disorder are:

Same as any other condition.

Diabetes Self Management

Benefits paid for diabetes self management are:

Subject to the plan deductible.

80% of Covered Charges.

Training: Includes one visit after initial diagnosis, one visit if significant change in condition, one visit for refresher training.

MEDICAL AIDS

Prosthetic Devices

Covered services are the initial purchase, fitting, repair, and replacement of fitted devices which replace body parts or perform bodily functions.

Benefits paid for prosthetic devices are:

Subject to the plan deductible.

80% of Covered Charges.

Durable Medical Equipment (DME)

Covered services are the rental, initial purchase, repair and replacement of equipment that is appropriate for home use and manufactured mainly to treat the injured or ill.

Benefits paid for DME are:

Subject to the plan deductible.

80% of Covered Charges.

EXCEPTIONS: Routine maintenance is not a covered service and Covered Charges for deluxe items are limited to the cost of standard items.

Orthotic Appliances

Covered services are the initial purchase, fitting, repair and replacement of braces, splints, and other appliances used to support or restrain a weak or deformed part of the body.

Benefits paid for orthotic appliances are:

Subject to the plan deductible.

80% of Covered Charges.

EXCEPTIONS: Foot support devices, such as arch supports and corrections to footwear, are covered only when prescribed by a physician. Standard elastic stockings, garter belts, and other supplies not specifically made and fitted are not covered services.

BLOOD

Covered services include donation of the enrollee's own blood prior to a surgical procedure. Processing of the blood is a covered service only if the enrollee received the blood.

Benefits paid for blood are:

Subject to the plan deductible.

80% of Covered Charges.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME

Covered services for TMJ Syndrome are inpatient hospital charges, office visits, diagnostic services, orthotic appliances, equilibrations, crowns, orthodontia, and surgery.

Benefits paid for TMJ Syndrome are:

Same as any other condition, based on place of service.

HOME HEALTH CARE

Covered services are non-custodial medical and nursing care to home confined patients who are referred to a home health care agency by a physician.

Benefits paid under the Standard Plan for home health care are:

Subject to the plan deductible.

80% of Covered Charges.

Benefits paid under the Blue Access Plan for home health care are:

100% of Covered Charges.

Limit: Custodial care is a non-covered service.

DENTAL FACILITY PHYSICIAN

Covered services are inpatient and/or outpatient provider facility services and inpatient and/or outpatient physician's services for dental care, when the provider facility setting is necessitated by a concurrent medical condition; for a mentally or physically impaired insured.

Benefits paid for dental facility physician are:

Same as any other condition.

Limit: This provision does not apply to services or supplies for temporomandibular joint syndrome.

DENTAL CARE ORAL SURGERY

Covered services include the extraction or removal of impacted or unerupted teeth for inpatient or outpatient services.

Benefits paid for oral surgery are:

Same as any other condition.

PHARMACY NETWORK (Applicable to active employees and retirees)

Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigational, in order to be covered. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before the Contractor on behalf of the State, can determine Medical Necessity. The Plan, in its sole discretion, may establish quantity limits for specific prescription drugs. Coverage will be limited based on Medical Necessity, quantity limits established by the Plan, or utilization guidelines. Prior Authorization may be required for certain drugs.

The enrollee should ask the Provider or network pharmacist to check with the Contractor, on behalf of the State, or the Administrator to verify Formulary Drugs, any quantity limits, or appropriate brand or generic drugs recognized under the enrollee's plan.

Definitions

For the purposes of this provision, the following definitions apply:

"Administrator" means an organization or entity that the Contractor on behalf of the State, contracts with to provide administrative and claims payment services.

"Brand Name Drug" means the initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic.)

"Copayment" means the amount that an enrollee must pay the Network Pharmacy or Mail Service Pharmacy for each Prescription Order before the prescription can be filled.

"Formulary" means a listing of Prescription Legend Drugs which includes brand and generic equivalents, medical supplies and devices which may be periodically amended, which Providers should use in prescribing prescription drugs. Drugs placed on the Formulary are chosen by a Pharmacy & Therapeutics Committee. When a drug is considered for the Formulary, inclusion of the drug is typically examined relative to similar drugs on the Formulary. Entire therapeutic classes are periodically reviewed. This review may result in deletion or non Formulary status of drugs in a particular therapeutic class, in an effort to continually promote the most clinically useful and cost effective agents. Drugs evaluated by the Pharmacy and Therapeutics Committee may not be added to the Formulary due to belief that the drug offers no known clinical or cost advantage over comparable formulary drugs, or there is currently insufficient scientific information to determine the drug's appropriate clinical role.

"Generic Drugs" means drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

"Mail Service" means a prescription drug program which offers a convenient means of obtaining maintenance medications by mail if the enrollee takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Administrator and/or Contractor, on behalf of the State, and sent directly to the enrollee's home.

"Network Pharmacy" means a Pharmacy who has entered into a contractual agreement or is otherwise engaged by the Administrator and/or the Contractor, on behalf of the State, or with another organization which has an agreement with the Administrator and/or Contractor, on behalf of the State, to provide covered prescription drugs and supplies to the enrollee.

“New FDA Approved Product or Technology" means the first release of the brand name product or technology upon the initial FDA New Drug Approval or other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

"New FDA Approved Drug Product or Technology" does not include:

- New formulations: A new dosage form or new formulation of an active ingredient already on the market;
- Already marketed drug product but new manufacturer: A product that duplicates another firm's already marketed drug product: same active ingredient, formulation, or combination;
- Already marketed drug product, but a new use: A new use for a drug product already marketed by the same or a different firm; or
- Newly introduced generic medications (generic medications contain the same active ingredient as their counterpart brand-name medications).

"Non-Network Pharmacy" means a Pharmacy who has not entered into a contractual agreement with the contractor and/or the Contractor.

"Pharmacy" means an establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Pharmacy or a non-Network Pharmacy.

"Pharmacy and Therapeutics Committee" means a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

"Prescription Legend Drug" means a medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label,

"Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

"Prescription Order" means a written request by a Physician for a drug or medication and each authorized refill for same.

"Prior Authorization" means the process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Covered Prescription Drugs

Covered prescription drug benefits include the following:

- Prescription Legend Drugs dispensed in accordance with the Formulary or outside of the Formulary.
- Injectable insulin and syringes used for administration of insulin.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical foods means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered intravenously under the direction of a Physician.

Exceptions

The following are not covered:

- Over the counter drugs, or Prescription Legend Drugs with over the counter equivalents.
- Off label use, except as otherwise prohibited by law.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician.
- Drugs for treatment of obesity, including any drug which is primarily for weight loss.
- Oral contraceptives (covered if treating a medical condition).
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law) except for injectable insulin.
- Drugs in quantities which exceed the limits established by the Plan.
- Retin-A (covered if treating a medical condition).
- Vitamins (covered if treating a medical condition).
- Fluoride treatment.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Drugs for infertility treatment.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

Copayment

Each Prescription Order may be subject to a Copayment. If the Prescription Order includes more than one covered drug, a separate Copayment will apply to each covered drug.

Days Supply

The number of days supply of a drug which the Enrollee may receive is limited. The days supply limit applicable to Prescription drug coverage is shown below. The days supply may be less than the amount shown due to Prior Authorization, quantity limits, and utilization guidelines.

Formulary

The Contractor, on behalf of the State, follows a drug Formulary in determining payment and Covered Charges. The Enrollee will be responsible for a greater Copayment if a Non-Formulary drug is obtained.

Payment Of Benefits

The amount of benefits paid will be based upon whether the Enrollee receives prescription drugs from a Network Pharmacy, Non-Network Pharmacy or a Mail Service Program, and whether a generic or brand name Prescription Legend Drug is obtained and whether Formulary Prescription Legend Drugs were dispensed. Please see below for the applicable amounts, and for applicable limitations on number of days supply.

NOTE: If the Enrollee obtains a brand name drug, the brand name drug Copayment will always apply, even in the following situations:

- No generic equivalent is available; or
- The Prescription Order specifies "Dispense as Written."

The amounts for which the Enrollee is responsible are shown below. No payment will be made by the Contractor, on behalf of the State, for any prescription drug unless the charge exceeds any applicable Copayment for which the Enrollee is responsible.

* Copayments, co-insurance and deductible amounts for Prescription Orders (or Drugs) are based on the Reasonable Charge of the provider at the applicable point of sale. Any discounts, rebates or other funds received by the Administrator and/or the Contractor, on behalf of the State, from drug manufacturers or similar vendors are excluded from the calculation of the Reasonable Charge.

Days Supply

Prescription Order obtained from a Network Pharmacy are limited to a 34 day supply or 100 units whichever is less.

Prescription Orders obtained from the Mail Service program are limited to a 90 day supply.

Network Pharmacy

Benefits paid for prescription drugs provided through a Network Pharmacy are:

Not subject to the Plan Deductible.

Subject to a Copayment of:

- $7.50 Copayment per Prescription Order for a Generic Formulary Drug.
- $12.50 Copayment per Prescription Order for a Brand Name Formulary Drug.
- 50% for Non – formulary.

Mail Service Program

Benefits paid for prescription drugs provided through the Mail Service program are:

Not subject to the Plan Deductible.

Subject to a Copayment of:

- $8.50 Copayment per Prescription Order for a generic Formulary Drug
- $25.00 Copayment per Prescription Order for a brand Name Formulary Drug
- 50% for Non- Formulary

Non-Network Pharmacy

Repriced at the in network rates less a 20% penalty plus $12.50 Copayment for a brand name formulary drugs

Repriced at the in network rates less a 20% penalty plus $7.50 Copayment for a generic formulary drugs

Repriced at the in network rates less a 20% penalty plus 50% Copayment for non- formulary drugs.

INJECTABLE DRUGS AND HOME INFUSION (IV) THERAPY

Covered Services are injectable drugs when ordered by a Physician, intravenous antibiotic therapy, total parenteral nutrition, enteral nutrition (when only source of nutrition), hydration therapy, solutions additives, and intravenous pain management.

Benefits paid for injectable drugs, including home infusion therapy drugs, are:

Subject to the plan deductible.

80% of Covered Charges.

EXCEPTION: Covered Services do not include the following:
- Insulin, Insulin syringes, and/or supplies.
- Experimental/Investigational drugs.

NOTE: Benefits are payable for Medically Necessary injectable drugs when ordered by a Physician. Services must be rendered by a retail pharmacist (including take-home drugs), a licensed medical supply company, or a home health care provider.

Benefits payable also for Medically Necessary home infusion (IV) therapy drugs, when ordered by a Physician and provided in the home. Services must be provided by a retail pharmacist (including take home drugs), a licensed medical supply company, or a home health care provider.

Covered Charges are based on the Reasonable Charge.

Limit: A physician's prescription must be included for each drug to be covered.

PART V: DENTAL

MAJOR DENTAL

DEDUCTIBLE

The Major Dental deductible is:

$25.00 per enrollee, or $75.00 per family.

The dental deductible does not apply to the plan deductible or the out-of-pocket maximum.

The deductible period is:

January 1 through December 31.

Deductible carryover:

Any Covered Charges which are incurred during the last three (3) months of the calendar year and applied to the dental deductible will be used to meet the next calendar year's dental deductible.

The following are covered services, when rendered by a dentist.

Class I - Preventive and Diagnostic Covered Services

- Oral examinations, not more than twice a calendar year.
- X-rays - Bitewing X-rays.
- X-rays - Full mouth X-rays, once in a 36 consecutive month period.
- Oral prophylaxis (cleaning and scaling of teeth) not more than twice in a calendar year.
- Topical fluoride treatment not more than one treatment in a calendar year.
- Space maintainers.

Benefits paid for Class I services are:

Not subject to the major dental deductible

100% of billed charges.

The combined plan maximum for Class I, II & III type services is:

$1,500.00 per enrollee, per calendar year.

Class II - Restorative Covered Services

- Extractions (except extractions for orthodontics).
- Fillings, including silver amalgam, silicate and acrylic restorations.
- Administration of general anesthetics when medically necessary and administered in connection with oral surgery.
- Periodontal treatment (diseases of gums).
- Endondontic treatment (pulp infection and root canal therapy).
- Injections of antibiotic drugs.
- Sealants for dependent children under 19 years of age on posterior teeth.
- Apicoectomy (considered a separate service if performed with root canal therapy)
- Gingivectomy or gingivoplasty, per quadrant.

- Osseous surgery, per quadrant. If more than one surgical service is performed per quadrant, only the most inclusive surgical service performed will be a covered service under this benefit. Flap entry and closure is considered part of the dental service of osseous surgery and osseous graft.
- Repairs and adjustments to full or partial dentures, only if performed after six (6) months from initial installation.
- Replacement of broken tooth of full or partial denture, only if not in conjunction with other repairs.

Benefits paid for Class II services are:

Subject to major dental deductible.

90% of billed charges.

The Benefit Period for Class II services is:

January 1 to December 31

The combined plan maximum for Classes I, II & III type services is:

$1,500.00 per enrollee, per calendar year.

Class III - Prosthodontics Covered Services

- Crowns (porcelain and/or gold).
- Complete dentures.
- Partial dentures.
- Bridge pontics (gold, porcelain, or plastic).
- Abutment crowns (gold, porcelain, or plastic).

Benefits paid for Class III Services are:

Subject to major dental deductible.

70% of billed charges.

The combined plan maximum for Class I, II & III type services is:

$1,500.00 per enrollee, per calendar year.

Class IV - Orthodontic Covered Services

- Orthodontic diagnostic procedures (including cephalometric X-rays).
- Surgical therapy (surgical repositioning of the jaw, facial bones, and/or teeth to correct malocclusion).
- Appliance therapy (braces) including related oral exams, surgery and extractions.

Benefits paid for Class IV Services are:

Subject to major dental deductible.

70% of billed charges.

The Plan maximum for Class IV type services is:

$2,000.00 per enrollee lifetime maximum.

Limitations

Covered services for surgery involving the teeth or peridontium are limited to the following:

- Excision of epulis.
- Excision of an unerupted impacted tooth, including removal of alveolar bone and sectioning tooth.
- Removal of a residual root (when performed by a dentist other than the one who extracted the tooth.
- Intraoral drainage of an acute alveolar abscess with cellulitis.
- Alveolectomy.
- Gingivectomy for gingivitis or periodontitis.

Exceptions

The following are not covered under dental:

- Services and supplies for lost or stolen dentures or appliances.
- Hospital charges, even if the admission is for dental work.
- Replacement of a bridge or denture within five (5) years following the date of its original installation unless:
    1. Replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or
    2. The bridge or denture, while in the oral cavity, has been damaged beyond repair as a result of an injury received while you are covered under this plan.
- Replacement of a bridge or denture, at any time, when the bridge or denture meets or can be made to meet commonly held dental standards of functional acceptability.
- Appliances or restorations, except full dentures when the primary purpose is to alter vertical dimension, stabilize periodontally involved teeth, or restore occlusion.
- Veneers or similar properties of crowns and pontics placed on, or replacing teeth, except the ten upper and lower anterior teeth.
- Services and supplies excluded in the exclusions section.

PART VI: VISION

COVERED BENEFITS	MEMBER BENEFIT FROM ANTHEM VISION NETWORK PROVIDER	NON-NETWORK REIMBURSEMENT*
Vision Examination Each member is entitled to a vision examination by an Anthem Vision provider. ***Availability: Once per Calendar Year*****	$15 copayment	Up to $50
Lenses A choice of glass or plastic (CR39) lenses in single vision, bifocal or trifocal (FT 25-28); lenses up to 55 mm; and all ranges of prescriptions.	$15 materials copayment applies to lenses and frames	
Single Vision Lenses		Up to $50
Bifocal Lenses (pair)		Up to $70
Progressive Lenses (pair) - Maximum allowable amount equal to bifocal amount. Member pays difference.		
Trifocal Lenses (pair)		Up to $90
Lenticular ***Availability: Once per Calendar Year***		Up to $110
Frames Maximum allowable amount of **$120** (retail) for frames purchased from Network provider. Member pays Preferred Price in excess of maximum allowable amount. ***Availability: Once per Calendar Year***		Up to $50
Contact Lenses***		
Elective – Members have a **$75** plan allowance per benefit period toward cosmetic contact lenses *in lieu of the frame and lens benefits*. If the member chooses contact lenses greater than the plan allowance, the member is responsible for the difference.	$15 copayment – additionally, the plan provides 10% discount on disposable lenses and 15% on other traditional lenses	Up to $75
Non-elective – Contact lenses which are prescribed for the following conditions: • following cataract surgery; • extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses. Covered up to **$120** in network. ***Availability: Once per Calendar Year***	$15 copayment	Up to $75

**Non-network reimbursement represents Plan Allowance towards eligible benefits and may not cover all charges.*
***From your last date of service*
****See Membership Certificate for definitions of Elective and Non-elective Contact Lenses*

This section describes the Covered Services available under your vision care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed herein and all other conditions and limitations of the Plan Description. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- Vision examinations
- Lenses
- Frames

Services and materials obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

If an Enrollee elects either covered Non-Elective or Elective Contact Lenses within one calendar year, no benefits will be paid for covered lenses and frames until the Enrollee's next calendar year.

NON-ELECTIVE CONTACT LENSES

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or glasses benefit.

ELIGIBILITY

Conditions that provide eligibility for consideration of this Non-Elective Contact Lens benefit include:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding –12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected three (3) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

FITTING FEES

The Enrollee is responsible for 100% of the fitting fee at the time of service. However, the Contractor's Reasonable Charge reimbursement paid to the prescribing Provider for Non-Elective Contact Lenses may include a portion, or all, of the fitting fee. Any remaining amount will be applied to the Provider's fitting fee.

Special Note: We will not reimburse for Non-Elective Contact Lenses for any Enrollee who has undergone prior elective corneal surgery, such as Radial Keratotomy (RK), Photorefractive Keratectomy (PRK), or Lasik.

MATERIALS OPTIONS

Benefits are available for the services below in accordance with the Schedule of Benefits. The Enrollee will be responsible for the following items when the charges exceed the Reasonable Charge.

- Blended lenses;
- Contact lenses (except as noted herein);
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromatic lenses, or tinted lenses other than Pink #1 or #2;
- Coated lenses;
- Frames that exceed the Reasonable Charge;
- Low Vision (except as noted herein);
- Cosmetic Spectacle Lenses;
- Optional cosmetic items;
- UV-protected lenses.
- For sunglasses and accompanying frames.
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For Orthoptics or vision training and any associated supplemental testing.
- For non-prescription lenses.
- For two pairs of glasses in lieu of bifocals.
- For Plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Enrollee has reached his or her normal interval for service when seeking replacements.
- For services or supplies not specifically listed herein.

OBTAINING SERVICES/CLAIM PAYMENT

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. If you elect to obtain services from a Non-Network Provider you must pay the entire bill at the time the services are rendered. To request reimbursement for Covered Services the Contractor will need the following information:

- The name, address and phone number of the Non-Network Provider along with an itemized statement of charges
- The covered Enrollee's name and address, group number, Social Security number or identification number
- The patient's name, birth date and relationship to the Enrollee

The Enrollee should keep a copy of the information and send the originals to the following address:

Blue Vision Claims Administration
555 Middle Creek Parkway
Colorado Springs, CO 80921

PRESCRIPTION SUNGLASS BENEFIT

Benefits paid for prescription sunglasses, applicable to the following schedule:

$50.00 per examination, limited to one per calendar year
$50.00 per frame, limited to one every two years
$50.00 per pair of single lenses
$70.00 per pair of bifocal lenses
$90.00 per pair of trifocal lenses
$110.00 per pair of lenticular lenses

This benefit applies only to covered employees and not to Dependents.

Claims for prescription sunglasses should be sent to:

Customer Service Manager
220 Virginia Avenue
Mail #IN22D-413
Indianapolis, Indiana 46204-3632

PART VII: EXCLUSIONS

This plan provides no benefits for:

- Unless specifically stated in this plan's benefits' article, care and supplies related to:

- Services and supplies for: (1) artificial insemination; (2) in vitro fertilization; (3) embryo transfer; (4) sterilization reversal; (5) gamete intra fallopian transfer (GIFT); (6) gender change; (7) any other fertility or infertility treatment; or (8) improving or restoring sexual function.

- Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

- Services and supplies for artificial heart implants.

- Services and supplies for animal organ or artificial organ transplants.

- Eyeglasses, contact lenses, or examinations to prescribe or fit such items (eye refractions), except that the cost of the first pair of either eyeglasses, contact lenses, or intraocular lenses required following cataract surgery is not excluded.

- Services or supplies for hearing aids, devices, or implants, or for the examination for their prescription and fitting.

- Services or supplies which the Plan determines are not Medically Necessary.

- Services or supplies for custodial care which is care that primarily meets personal rather than medical needs and which can be provided by persons with no special medical skills or training.

- Standby charges of a physician.

- Services and supplies for dental, except as specifically stated in the plan's articles.

- Private duty nursing services except when provided through the plan's home health care benefit.

- Charges which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Plan.

- Treatment and care connected with or incidental to treatment, that is intended primarily to improve personal appearance. Benefits will be provided for care and treatment intended to restore bodily function or correct deformity resulting from disease, accidental injury, birth defects, or previous therapeutic process.

- 1) Care of flat feet; 2) supportive devices of the foot, (unless specifically made for and fitted to a particular individual; 3) care of corns, bunions, or calluses; 4) care of toenails; and 5) care of fallen arches, weak feet, or chronic foot strain, except that 3) and 4) are not excluded when medically necessary because the enrollee or covered dependent is diabetic or suffers from circulatory problems.

- Services or supplies for occupational accidents and diseases which are or could have been paid for or available under the requirements of Worker's Compensation and Occupational Disease Law. This exclusion does not apply if the enrollee is not eligible for Worker’s Compensation benefits.

- Services and supplies for research studies or screening examinations, except as specifically stated in the plan articles.

- Services or supplies used to treat conditions related to autism, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or senile deterioration, beyond the period necessary to diagnose the condition.

- Services or supplies provided for, or in connection with, care or treatment of any illness or injury due to war or any act or war. "War" includes armed aggression resisted by the armed forces of any country, combination of countries, or international organization, whether or not war is declared.

- Services or supplies to the extent the enrollee has no legal obligation to pay for.

- Expenses incurred before an enrollee's coverage under the plan becomes effective or after it ends, except as specifically stated elsewhere in this plan.

- Services or supplies provided by a sanitarium, or rest cures.

- Services or supplies furnished by any person or institution acting beyond the scope of his/her/its license.

- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.

- Services or supplies received from a dental or medical department maintained by or on behalf of a State, a mutual benefit association, labor union, trust, or similar person or group.

- Services provided by any governmental agency to the extent provided without cost to the enrollee except as this exclusion may conflict with federal or state law.

- Travel, whether or not recommended by a physician.

- Services or supplies if the plan does not state that benefits are provided for them.

- Charges for: telephone consultations, charges for failure to keep a scheduled visit, completing attending physician's statements or claim forms, or other services not part of the direct medical care of the patient.

- Recreation or diversional therapy.

- Hospitalization for environmental change or provider individual charges connected with prescribing an environmental change.

- Temporomandibular Joint (TMJ) Syndrome, except as specifically stated in the plan's benefits.

- Charges for intrauterine devices, diagnosis, or birth control medications when used solely for contraceptive purposes.

- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a physician.

- Services or supplies, provided for the treatment of obesity and/or weight control, except for surgical treatment of morbid obesity.

- Speech therapy, except when received as a result of congenital anomalies or following an accident, stroke or surgery or disease.

- Dental services or supplies that are necessary because a denture or orthodontic appliance was lost or stolen.

- Dental sealants for patients age nineteen (19) or over.
- Dental sealants other than for posterior teeth.
- Vision care services, unless medically necessary due to accident or disease.
- Durable medical equipment which benefits others in the enrollee's household, other than the patient, even when prescribed by a physician.
- Services or supplies used to treat an enrollee or covered dependent who becomes sick or injured due to: participating in a riot, civil disturbance, or street violence; or committing or attempting to commit an assault or a felony.
- Services and supplies provided primarily for educational, vocation, or training purposes.
- Services or supplies for radial Keratotomy or for kertomileusis.
- Treatment in any facility which is mainly a place for: rest, convalescence, custodial care, the aged, rehabilitation, training, schooling or occupational therapy.
- Environmental control equipment and modifications to the home, property or equipment.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment or for licensing are not covered.
- Services or supplies for which claims are not timely filed, according to this contract's claim filing provisions.
- Appliances, restorations or procedures for the purpose of splinting or implantology, or to alter vertical dimension or restore occlusion.
- Services and supplies for veneers or similar properties of crowns or pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth.
- Services and supplies for replacement of a lost, missing, or stolen dental prosthetic device.
- Services and supplies for replacement or repair of an orthodontic appliance.
- Services and supplies for implantology.
- Services and supplies for dental prosthetic devices, (including bridges and crowns) and fitting thereof, which were ordered while the individual was covered under this plan, but which are finally delivered or installed more than 60 days after termination of coverage.
- Anything not furnished by a physician, except X-rays ordered by a dentist, and services by a licensed dental hygienist under the dentist's supervision.
- Expenses applied toward satisfaction of a deductible under this dental exhibit.
- Facings on molar crowns or pontics or any other services for cosmetic purposes unless made necessary by an accident occurring while covered.
- Replacement or modification of a crown, gold restoration, denture, or fixed bridge, or addition of teeth to the denture or bridge, if the initial dental work was performed less than five (5) years before the current service.

- Prescription drugs dispensed from a pharmacy with the intent of home administration or consumption. These claims are to be filed with the prescription drug carrier.

- Services or supplies for duplication of X-rays.

- Services or supplies for sterilization of dental appliances.

- Services or supplies for bleaching.

- Services or supplies for applying desensitizing medication.

- Take home fluoride.

- Services or supplies for initial installation of a denture or bridgework to replace teeth the enrollee lost before the effective date of this dental plan.

- Periodontal splinting.

- Oral care instructions, for example, hygiene or diet.

- Dental services and supplies primarily for cosmetic or esthetic purposes.

- Plaque control programs, oral hygiene and dietary instructions.

- Dental prosthetics.

- Services and supplies related to extra sets of dentures or other devices or appliances.

- Dental appliances (for example, night guards) used to correct harmful habits.

- Dental bonding.

- Services or supplies in excess of the Reasonable Charge.

- Services and supplies in a skilled nursing facility.

- Services and supplies for hospice care.

- Wigs and artificial hair except for specifically stated in the plan's benefits.

- A denture or fixed bridge involving replacement of teeth extracted before the patient was covered under this Plan, unless: the denture or fixed bridge replaces a tooth that was extracted while the patient was covered under this plan; and such tooth was not an abutment for a denture or fixed bridge installed during the preceding five (5) years.

- Charges for: a) the care and treatment of the teeth, gum or alveolar process, except as specifically provided for under this plan, b) dentures, appliances or supplies used in such care and treatment unless such expenses are incurred as a result of an accident which occurred while the enrollee was receiving coverage under this plan.

- An appliance, or modification of one, where an impression was made before the patient was covered under this plan; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered under this plan; or root canal therapy if the pulp chamber was opened before the patient was covered under this plan.

- If you change dentists during the treatment program, the benefits provided will be the same as if only one dentist had performed treatment.

PART VIII: GENERAL PROVISIONS

ELIGIBILITY

Employees

All active full-time Indiana State Police employees regularly scheduled to work not less than 37 ½ hours per week are eligible, as are disabled employees, their spouses and their eligible "dependents".

An eligible dependent of an employee becomes eligible for coverage on the effective date of the employee's coverage.

If a dependent, other than a newborn infant of an enrollee, is confined in a hospital on the date his or her coverage would otherwise begin, his or her coverage will become effective upon final medical release from such confinement.

Retirees

A retiree becomes eligible for coverage either: 1) the month he or she retires (if the retirement becomes effective on the first day of that month); or 2) the first day of the month following the date retirement becomes effective, if he or she:

- Has completed 20 years of creditable service; or
- Is age 62 and have completed 10 years of creditable service; or
- Is age 60 and have completed 15 years of creditable service; or
- Is age 55 and age plus creditable years of service equals 85 or more.

Additional eligibility requirements for retiree coverage:

Employees hired prior to July 1, 2000 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan by no later than January 1, 2002 and maintain continuous coverage from that date to date of separation of the employment with the department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes credited coverage under this provision.

Employees hired after July 1, 2000 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan by the first or second enrollment following hire provided the employee is enrolled within 18 months of date of hire and maintains continuous coverage from that date to date of separation of the employment with the department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes credited coverage under this provision.

A retiree must elect coverage on the first day he or she becomes eligible, or within 30 days of the eligibility date. Late entrants (after the 30 day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Premium contributions for retirees covered under the Indiana State Police Pension Fund are paid directly to the plan administrator by monthly coupon billing for the first three (3) months of retirement. At the retiree's option coupon billing may continue or premiums can then be paid on a monthly basis by deductions from the pension check.

Retirees upgrading coverage from the basic plan to the optional plan must maintain the upgraded coverage for a period of not less than three years before reducing coverage.

All retirees covered by PERF must be coupon billed.

Retiree Dependents

An eligible dependent of a retiree becomes eligible for coverage on the effective date of the retiree's coverage.

"Dependent" – The following persons, provided coverage under the plan is in effect:

- The eligible person's spouse.
- Any of the following who qualify as the eligible person's dependent(s), until they reach the limiting age:
  1. Unmarried children;
  2. Unmarried stepchildren;
  3. Unmarried adopted children of the eligible person or spouse, from the earlier of: (a) the date of placement for the purpose of adoption; (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption; or
  4. Unmarried children for whom the eligible person or spouse has legal guardianship when both parents of the unmarried child are deceased and one of the parents of the unmarried child is a enrollee of the enrollee's immediate family provided the unmarried child resides with the eligible person or spouse except in those cases when the child is no longer a same household resident while a full time student at an accredited educational institution.
  5. Those dependents enrolled through guardianship prior to July 1, 2000 will remain covered dependents until the earlier of:
     a. The dependent reaches the dependent limiting age: or
     b. The enrollee is no longer the legal guardian of the dependent: or
     c. The enrollee terminates coverage of the dependent for any reason. In this occurrence, any reinstatement of coverage for the dependent will be subject to the requirements of the insurance plan for the department then in effect.
- In the event a child who is a "dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the enrollee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the dependent limiting age is reached for the "dependent" will continue until the enrollee discontinues his coverage or the disability no longer exists. The department may require, at reasonable intervals, but no more often than once a year, satisfactory evidence of the disability is continuing.

"Dependent Limiting Age" is the end of the calendar year of the child's 19th birthday, or the end of the calendar year of the child's 24th birthday if the child qualifies as a federal tax exemption.

FAMILY SECURITY

If an employee or retiree is covered under this program at the time of his or her death, his or her dependents, including spouse, who are also covered will be eligible to remain covered under this Plan under the family security program without payment of premiums for a period of twenty-four (24) months, or until the occurrence of one of the following events, whichever is earliest:

- If the dependent becomes eligible for Medicare on the date of the employee's or retiree's death, the last day of the sixth (6th) month after the employee's or retiree's death; or
- If the dependent qualifies for Medicare after the employee's or retiree's death, the date the dependent qualifies for Medicare; or
- The date of remarriage of the surviving spouse, if any; or
- The date the dependent ceases to meet this Plan's definition of a dependent.

After the family security program has terminated, the remaining covered dependents may continue their coverage at the appropriate dependent premium rate based on the retiree rate structure.

After the family security program has terminated, the covered dependents of employees killed in the line of duty may continue their coverage at the appropriate dependent premium rate based on the active employee rate structure.

Health/Vision only and Dental only coverage will not apply. This rate will apply to such dependents until the surviving spouse becomes Medicare eligible at which time the retiree Medicare supplement rates will apply.

Election to continue coverage following the family security period must be made within 30 days of notification of the end of family security. Coverage elected will become effective on the first day of the month two years after enrollee's death. Late entrants (after the 30-day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

However, coverage for the spouse will cease on the earlier of:

- The date of remarriage of the surviving spouse; or
- The date the surviving spouse dies.

Any coverage which is continued for dependent children because of the death of a covered employee or retiree will not cease because of the death of the surviving spouse within the twenty-four (24) month period following the date of the employee's or retiree's death.

The dependent benefits payable after the death of the employee or retiree will be those in effect for the dependents on the day prior to the death of the employee or retiree.

ENROLLMENT

Participation in the plan(s) is voluntary, and employees may enroll as follows:

- New employees are given thirty-one (31) days from their date of hire to enroll in any of the programs offered by the Indiana State Police. Coverage becomes effective on the date they elect coverage by signing an approved payroll deduction form. Coverage for dependents takes effect when the employee becomes covered.
- Dependents born or acquired after the date of enrollment must be added by completion of the appropriate forms within thirty-one (31) days of the marriage, birth, etc.
- Enrollment or changes not in accordance with above paragraphs may be made as follows:

    1. During designated open enrollment periods;
    2. Based upon the evidence of insurability policy under the TPA;
    3. Based on the qualifying events interim in the IRS Code Section 125.

CONTRIBUTIONS

Persons who have elected coverage under the medical, vision and dental plans must authorize payroll deductions to pay their portion of the cost.

PRE-EXISTING CONDITIONS

All enrollees, disabilitants, retirees and their dependents are covered under this plan without regard to any pre-existing condition(s), except for those pre-existing conditions specifically identified in the Exclusion section. Coordination of benefits shall be accomplished by the contractor.

TERMINATION OF COVERAGE

Coverage for enrollees, and dependents will terminate on the earliest of:

- The date the contract or plan is terminated; or
- The date the payroll deduction authorization is withdrawn; or
- The date the premiums are due and payable and unpaid; or

- Termination of employment (except when retiree coverage is elected); or
- The date a dependent ceases to be eligible as defined; or
- The date the plan maximum of $1,000,000.00 per enrollee is met.

INCONTESTABILITY

The State may declare an enrollee's coverage null, or cancel it, if the application to establish it or to change it contains a material misrepresentation. However, unless the material misrepresentation is contained in a written document signed by the enrollee, this paragraph will not apply more than two (2) years after the enrollee's coverage has been in force or the request for change in the enrollee's coverage was made.

BENEFIT BOOKLETS

In the event of a conflict between the plan and the benefit booklet, the plan will prevail.

APPLICATIONS

To obtain coverage with the Indiana State Police Health Care Benefit Plan, an eligible person must complete and submit an application to the contractor. Acceptance of the application is shown by delivery of an identification card showing the eligible person's name and identification number.

NOTICE OF CLAIM

For benefits to be payable under the plan, the contractor must receive a claim by December 31 of the year following the year the service was received. However, the contractor will not reduce or deny benefits for failure to meet this time limit if the claim was filed as soon as it was reasonably possible for the enrollee to do so.

CLAIM FORMS

Claims must be filed on claim forms provided by the contractor. Often, the hospital, physician or other provider of service will file the claim. If the service provider will not file, the Enrollee may obtain claim forms from the contractor's office or the State.

CLAIM PAYMENT

The contractor on behalf of the State, will pay all benefits available under the plan within 45 days after receiving all information required to determine liability under the plan.

The contractor will pay benefits due under the plan to the enrollee, or, at its sole discretion, to the provider of service from which benefits are claimed, or, to both the enrollee and provider of service jointly. No enrollee or dependent may assign such payment.

If benefits due under the plan have been paid by other parties, the contractor may reimburse those other parties and be fully discharged from that portion of its liability.

MEDICAL EXAM

The contractor, upon approval of the State, may have a physician examine an enrollee for whom a claim is made under the plan as often as is reasonably required during the pendency of the claim. The contractor will notify the enrollee in advance of the time and place for such an examination.

LEGAL ACTION

No legal action to obtain the plan's benefits may be taken prior to 60 days after the contractor received the claim, or later than three (3) years after the date the claim is required to be furnished to the contractor.

CANCELLATION OF THE CONTRACT

The State may cancel the plan at any time by giving advance written notice. The cancellation will not be effective before the end of the period for which the State has paid premiums, according to the Schedule of Financial Variables.

CANCELLATION OF CONTRACT ENROLLMENT

If an eligible person makes a material misrepresentation on a claim for the plan's benefits, the contractor, on behalf of, the State, may cancel the enrollee's plan enrollment, effective on or anytime after the date of the claim, without giving advance notice to the enrollee. If an enrollee ceases to meet the plan's definition of an eligible person or dependent, that enrollee's plan enrollment is automatically canceled.

Cancellation of an eligible person's plan enrollment ends the eligible person's and dependents' coverage and all rights to the plan's benefits effective on the date of cancellation, except for any applicable extension of benefits provision. Cancellation of a dependent's plan enrollment ends the dependent's coverage and rights to the plan's benefits, effective on the date of cancellation, except for any applicable extension of benefits provision. An eligible person may cancel his or her coverage of a dependent's coverage at any time by giving advance written notice. The cancellation will be effective the end of a period for which coverage premiums have been paid.

COORDINATION OF BENEFITS (COB)

A. APPLICABILITY

1. This Coordination of Benefits (COB) provision applies to this plan when an enrollee has health care coverage under more than one plan. "Plan" is defined in Section B.

2. If this COB provision applies, review the Order of Benefit Determination Rules in Section C to determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

    a. Shall not be reduced when, under the Order of Benefit Determination Rules, this plan determines its benefits before another plan; but

    b. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. This reduction is described in Section D.

B. DEFINITIONS

1. "Plan" means this plan and any other arrangement providing health care or benefits for health care through:

    a. Group insurance coverage, health maintenance organizations, self-insurance plans, and preferred provider organizations;

    b. Prepayment coverage;

    c. Any other coverage which as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, a union welfare plan, an employee organization plan or an employee benefit organization;

    d. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization;

    e. Any government program except Medicare or Medicaid;

    f. The medical payments and/or No-fault provisions of automobile insurance;

g. Any other group type coverage as permitted by law.

2. A "Plan" is not any of the following:

   a. Individual or family coverage, including insurance contracts, enrollee contracts, coverage through health maintenance organizations or other prepayment group practice and individual practice plans which are not group coverages;

   b. The first $100.00 per day payable by a group or group-type hospital indemnity plan;

   c. Any school accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis; and

   d. Any other coverage when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

3. "Primary Plan/Secondary Plan". The Order of Benefit Determination Rules determines whether this plan is a primary plan or secondary plan as to another plan covering the enrollee.

   When this plan is a primary plan, its benefits are determined before those of the other plan without considering the other plan's benefits.

4. “Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the enrollee. When a plan provided benefits in the form of services, the reasonable cash value of each service is the allowable expense. When benefits are reduced under a Primary Plan because the enrollee does not comply with the primary plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

   However, a secondary plan may not refuse to pay benefits because a health maintenance organization (HMO) enrollee has elected to have health care services provided by a non-HMO Provider and the HMO, pursuant to its contract, is not obligated to pay for those services.

C. ORDER OF BENEFIT DETERMINATION RULES

1. When there is a basis for a claim under this plan and another plan, this plan is the secondary plan if:

   a. The other plan does not have rules coordinating its benefits with this plan; or

   b. Either the other plan's rules, this plan's rules, or both, require that this plan's benefits be determined after those of the other Plan, except as may occur under the gender rule exception in 2.b.2) below.

2. This plan's rules for determining the order of payment of benefits follow, using the first of the rules which applies:

   a. The plan covering the enrollee as the enrollee shall be deemed to be the primary plan and is obligated to pay before the plan covering the enrollee as a dependent.

   b. In the case of a dependent child, when the parents are neither separated nor divorced;

      1) The plan covering the enrollee as a dependent of the enrollee whose birthday falls earlier in the year shall be deemed to be the primary plan and is obligated to pay before the plan covering the enrollee as a dependent of the enrollee whose birthday falls later in the year;

2) If both enrollees have the same birthday, the plan which has covered the enrollee longer shall be deemed to be the primary plan and is obligated to pay before the plan which has covered the other enrollee for a shorter time.

EXCEPTION: If the other plan does not have the rule described in b. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. In the case of a dependent child, when the parents are separated or divorced, the first of the following which applies will determine the primary plan:

1) The plan which covers the child as a dependent of the parent with custody of the child;

2) The plan which covers the child as a dependent of the spouse of the parent with custody;

3) The plan which covers the child as a dependent of the parent without custody;

EXCEPTION: If there is a court decree which would otherwise establish financial responsibility for the medical, vision, dental or other health care expenses with respect to the child, and the contractor has actual knowledge of the court decree, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be deemed the primary plan. If the specific terms of a court decree state that the parents shall have joint custody without stating that one of the parents is responsible for the medical, vision, dental or other health care expenses of the child, the plans covering the child shall follow the order of payment in accordance with b. above.

d. The plan which covers the enrollee as a enrollee who is neither laid off nor retired shall be deemed to be the primary plan for that enrollee and any dependents and is obligated to pay before the plan covering that enrollee as a laid off or retired enrollee and any dependents. If the other plan does not contain this provision, and if, as a result the plans do not agree on the order of benefits, this provision is to be ignored.

e. If an enrollee has continuation coverage under a right of continuation pursuant to state or federal law, the plan covering the enrollee as an employee, enrollee, or as a dependent of an employee, enrollee, shall be deemed to be the primary plan and is obligated to pay before the benefits under the continuation coverage. If the other plan does not have this provision and if as a result the plans do not agree on the order of benefits, this provision is to be ignored.

f. Where the order of payment cannot be determined in accordance with a., b., c., and d. above, the primary plan shall be deemed to be the primary plan shall be deemed to be the plan which has covered the enrollee for the longer period of time.

EXCEPTION: If the enrollee is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

1) Secondary to the plan covering the enrollee as a dependent; and

2) Primary to the plan covering the enrollee as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the enrollee as a dependent are determined before those of the Plan covering that Enrollee as other than a dependent plan which has covered the enrollee for the longer period of time.

D. EFFECT ON THE BENEFITS OF THIS PLAN

1. When the enrollee is covered by two or more plans which, if they did not coordinate their benefits, would together pay more than the allowable expense, this plan's benefits will be paid according to the Order of Benefit Determination Rules. This plan's benefits payments will not be affected when this plan is primary as defined in the Order of Benefit Determination Rules. When this plan is secondary, as defined in the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that the combined benefits of all plans covering the enrollee do not exceed the allowable expense.

2. The amount by which this plan's benefits are reduced because it is secondary will accrue to the credit of the enrollee for the remainder of the calendar year. When the credit arises from a service provided in the last 90 days of the calendar year, the credit will be available for 90 days from January 1, of the following calendar year. This credit will never be applied to an extent that would cause the enrollee to receive a combined benefit from all plans greater than the allowable expense, or that would cause the enrollee to receive more benefits during a calendar year under this plan than he or she would have received in the absence of coordination of benefits.

E. RIGHT TO RECEIVE & RELEASE INFORMATION

In order to coordinate benefits, this plan allows the Contractor to release or obtain from any insurance company, organization, or person any information regarding a claim. Any enrollee claiming benefits under this plan must furnish the Contractor with any information necessary to coordinate benefits.

F. RIGHT TO OBTAIN RECOVERY

The Contractor, on behalf of the State, is not liable for any failure to coordinate benefits. If the Contractor on behalf of the State, pays full benefits on a claim for which it had only secondary liability, the Contractor may recover the difference from the enrollee or from any other appropriate party, even if the Contractor knew there were other plan liabilities at the time payment was originally made.

FEDERAL CONTINUATION OF COVERAGE (COBRA)

If the Enrollee is covered under a State which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the Plan provides that each of the qualified beneficiaries listed below has the right to choose continuation coverage if his or her coverage under the Plan would otherwise end. The election period lasts for 60 days and begins to run on the later of either the date that the qualified beneficiary would lose coverage due to the qualifying event or the date the qualified beneficiary is sent notice of the right to continuation coverage. Unless the election specifies otherwise, an election by a covered Enrollee or a spouse is also considered an election on behalf of any other qualified beneficiary who would also lose coverage due to that qualifying event.

For purposes of this section, "entitled to Medicare" means the effective date of enrollment in Medicare Part A or B, under Title XVIII of the Social Security Act, as amended. Eligibility to enroll in Medicare does not have the same meaning as entitled to Medicare.

Qualifying Events and Qualified Beneficiaries

The following qualified beneficiaries (not including nonresident aliens who received no income constituting earned income under federal law from the employer and the nonresident aliens' Dependents) have the right to continuation coverage when one of the following qualifying events results in a loss of coverage under the Plan:

1. Upon the death of the covered Enrollee: the spouse and Dependent children.
2. Upon the covered Enrollee's termination (for other than gross misconduct) or reduction in work hours: the Enrollee and his or her eligible Dependents.
3. Upon the divorce or legal separation of the covered Enrollee: the divorced or legally separated spouse and Dependent children.

4. Upon the covered Enrollee becoming entitled to Medicare under Title XVIII of the Social Security Act: the spouse and Dependent children.
5. Upon the disqualification of a Dependent child under the Plan's eligibility requirements: the Dependent child not meeting such requirements.
6 Upon the Employer's filing of a Title XI Bankruptcy: the retired covered Enrollee and his or her Dependents who:

    a. As a result of the bankruptcy filing would experience a substantial elimination of health coverage, under the Plan, within a year of the bankruptcy filing; or (b) has experienced an elimination of coverage during the year preceding the bankruptcy filing.

For the purposes of this section, coverage for a Dependent child includes coverage for any child born to or placed for adoption with a qualified beneficiary after a qualifying event if proper notice is provided to the Plan or the birth or adoption.

If a Spouse or Dependent Child of a Enrollee is covered through a Enrollee by alternative coverage, and the right to receive the alternative coverage will cease upon the death of or divorce or legal separation from the Enrollee, the end of the alternative coverage shall be considered a qualifying event as described in 1. and 3. above, regardless of whether the alternative coverage would satisfy COBRA continuation coverage rules. "Alternative coverage" means coverage provided by an Employer without regard to COBRA continuation coverage, as a result of: state or local law; industry practice; a collective bargaining or severance agreement; plan procedure; or disability or workers compensation leave.

Duration Of Continuation Coverage:

1. For the events explained in paragraphs "1," "3," "4," and "5" under "Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 36 months after the date of the initial qualifying event.

2. For the event explained in paragraph "2" under Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 18 months after the date of the qualifying event.

    Exceptions:

    a. If the qualifying event under paragraphs "1," "3," "4," or "5" above occurs during the 18-month period, continuation coverage will be continued an additional 18 months; or

    b. If a qualified beneficiary is determined under Titles II or XVI of the Social Security Act to be disabled at any time during the first 60 days of continuation coverage under paragraph "2," under "Qualifying Events and Qualified Beneficiaries," continuation coverage will be extended an additional 11 months.

        However, coverage will be extended only if the qualified beneficiary gives notice of the disability within 60 days after the disability is determined and before the end of the original 18-month continuation period. When the qualified beneficiary is no longer disabled, he or she must notify the employer within 30 days after the final determination is made under Titles II and XVI.

    c. If the Enrollee became entitled to Medicare prior to the qualifying event, the period of coverage for qualified beneficiaries other than the Enrollee shall be the longer of 18 months from the termination or reduction in hours of employment or 36 months from the earlier Medicare entitlement.

3. For the event explained in paragraph "6" above, continuation coverage is provided until the death of the retired covered Enrollee. If the covered Enrollee dies before the occurrence of the qualifying event, continuation coverage is provided until the death of the surviving spouse.

Upon the death of the covered Enrollee, his or her Dependents (other than a surviving spouse entitled to lifetime coverage) are entitled to continuation coverage as explained in paragraph "1" of the preceding section.

The maximum period for all qualifying events is 36 months, except as may occur under paragraph "3" immediately above.

Premiums

The qualified beneficiary must pay premiums for any period of continuation coverage. If the qualified beneficiary makes the election after the qualifying event, any premiums due must be paid by 45 days after the date of the election.

Cancellation

Continuation coverage will terminate if:

1. The State ceases to provide any group health Plan to its Enrollees;

2. Premiums are not paid on time;

3. Upon the date, after the date of continuation coverage election, the qualified beneficiary first becomes covered under another group health plan that:

    a. Does not contain any limitation regarding a pre-existing of the beneficiary; or

    b. Does contain a pre-existing exclusion or limitation that would apply to the beneficiary but is not applicable because of the Federal Health Insurance Portability and Accountability Act of 1996's rule on pre-existing condition clauses;

4. Upon the date, after the date of continuation coverage election, a qualified beneficiary other than beneficiaries that are provided continuation of coverage under paragraph "6," under "Qualifying Events and Qualified Beneficiaries," first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or

5. A qualified beneficiary who was disabled under paragraph "2," under "Qualifying Events and Qualified Beneficiaries," is no longer disabled. The additional 11 months of extended continuation coverage will be terminated on the first day of the month that begins more than 30 days after the date of the final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled.

Duplicate Payment

In the event an expense incurred could be covered under more than one benefit in this plan, the Contractor, on behalf of the State, will not duplicate payment under the various benefits available. However, consecutive payments for covered services will be provided as appropriate.

SUBROGATION - REIMBURSEMENT

These provisions apply when Plan benefits are paid as a result of injuries or illness sustained by the Enrollee and for which the Enrollee has a right to a Recovery or has received a Recovery.

Subrogation

The Contractor, on behalf of the State, has the right to recover payments made on behalf of the Enrollee from any party responsible for compensating the Enrollee for the Enrollee's injuries. The following apply:

- The Contractor, on behalf of the State, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether the Enrollee is fully compensated, and regardless of whether the payments the Enrollee receives makes the Enrollee whole for his or her losses and injuries.
- The Enrollee and the Enrollee's legal representative must do whatever is necessary to enable the Contractor, on behalf of the State, to exercise their rights and do nothing to prejudice them.
- The Contractor, on behalf of the State, have the right to take whatever legal action they see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Contractor's subrogation claim and any claim still held by the Enrollee, the Contractor's subrogation claim shall be first satisfied before any part of a Recovery is applied to the Enrollee's claim, attorney fees, other expenses or costs.
- The Contractor, on behalf of the State, is not responsible for any attorney fees, other expenses or costs without its prior written consent. The Contractor, on behalf of the State, further agrees that the "common fund" doctrine does not apply to any funds recovered by any attorney hired by the Enrollee regardless of whether funds recovered are used to repay benefits paid by the Contractor, on behalf of the State.

Reimbursement

If the Enrollee obtains a Recovery and the Contractor, on behalf of the State, has not been repaid for the benefits the Contractor, on behalf of the State, paid on the Enrollee's behalf, the Contractor, on behalf of the State, shall have a right to be repaid from the Recovery in the amount of the benefits paid on the Enrollee's behalf and the following apply:

- The Enrollee must reimburse the Contractor, on behalf of the State, to the extent of benefits the Contractor, on behalf of the State, paid on the Enrollee's behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Contractor, on behalf of the State, shall have a right of Recovery, in first priority, against any Recovery.
- The Enrollee and the Enrollee's legal representative must hold in trust for the Contractor, on behalf of the State, the proceeds of the gross Recovery (i.e., the total amount of the Enrollee's Recovery before attorney fees, other expenses or costs) to be paid to the Contractor, on behalf of the State, immediately upon the Enrollee's receipt of the Recovery. The Enrollee must reimburse the Contractor, on behalf of the State, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney the Enrollee hires regardless of whether funds recovered are used to repay benefits paid by the Contractor, on behalf of the State.
- If the Enrollee fails to repay the Contractor, on behalf of the State, the Contractor, on behalf of the State, shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Contractor, on behalf of the State, has paid or the amount of the Enrollee's Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount the Contractor, on behalf of the State, paid on the Enrollee's behalf is not repaid or otherwise recovered by the Contractor, on behalf of the State; or
  2. the Enrollee fails to cooperate.
- In the event that the Enrollee fails to disclose to the Contractor and/or the State the amount of the Enrollee's settlement, the Contractor, on behalf of the State, shall be entitled to deduct the amount of the lien from any future benefit under the Plan.
- The Contractor, on behalf of the State, shall also be entitled to recover any of the unsatisfied portion of the amount they have paid or the amount of the Enrollee's settlement, whichever is less, directly from the providers to whom the Contractor, on behalf of the State, has made payments. In such a circumstance, it may then be the Enrollee's obligation to pay the provider the full billed amount, and the Contractor, on behalf of the State, would not have any obligation to pay the provider.

- The Contractor, on behalf of the State, is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make the Enrollee whole.

The Enrollee's Duties

- The Enrollee must notify the Contractor, on behalf of the State, promptly of how, when and where an accident or incident resulting in personal injury or illness to the Enrollee occurred and all information regarding the parties involved.
- The Enrollee must cooperate with the Contractor, on behalf of the State, in the investigation, settlement and protection of the rights of the Contractor, on behalf of the State.
- The Enrollee must not do anything to prejudice the rights of the Contractor, on behalf of the State.
- The Enrollee must send the Contractor, on behalf of the State, copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to the Enrollee.

The Enrollee must promptly notify the Contractor, on behalf of the State, if the Enrollee retains an attorney or if a lawsuit is filed on the Enrollee's behalf.

ADMINISTRATION

The State and anyone acting on its behalf have full and discretionary authority over administering this Plan, including, but not limited to, the power to:

- Construe, interpret, and apply the provisions of this Plan;
- Determine questions concerning eligibility for participating, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of this Plan; and
- Perform the State's duties thereunder.

The State's actions shall be binding upon all interested parties.

SIMILAR COVERAGE

No enrollee whose coverage under the plan is in effect may have coverage under an individual health insurance contract or plan with the Contractor. An enrollee who has similar coverage under separate plans may retain only one plan with the Contractor.

An enrollee who chooses not to keep this coverage will receive a refund of any applicable coverage fee payments that apply to the period of similar coverage, minus benefits paid for expenses incurred by the enrollee during the refund period.

FEES

Amounts due the Contractor from the State are payable in accordance with the contract.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

Neither the Contractor nor the State is responsible for the quality of care an enrollee receives from any person. The plan does not give anyone any claim, right or cause of action against the Contractor or the State based on what a provider of health care of supplies does or does not do.

GOVERNING LAWS

This plan shall be governed by Indiana laws.

RIGHT OF RECOVERY

If the Contractor makes any payment that according to the terms of this plan should not have been made, including payment made in error under any plan exclusion, it may recover that incorrect payment, whether or not it was made due to the Contractor's own error, from the person to whom it was made or from any other appropriate party.

If any such incorrect payment is made directly to an enrollee, the Contractor may deduct it when making future payments directly to that enrollee.

RESPONSIBILITY OF THE GROUP

The State is the fiduciary of the enrollee.

CONFIDENTIALITY AND DISCLOSURE OF INFORMATION

This policy sets forth guidelines regarding an Enrollee's right to access and amend information in the Contractor's and/or State's possession. The policy specifically addresses when a release, signed by an Enrollee, is required before information may be disclosed by the Contractor and/or the State to parties such as an Enrollee's provider, spouse or other family members. The policy includes the following key points:

- At enrollment, Enrollees sign a consent form to allow the release of any information or records concerning claims, conditions, or treatments of the Enrollee, enrolled under the Plan for routine uses. Routine uses of Enrollee information include but are not limited to: payment of claims, health care operations, plan administration, quality improvement, utilization review, coordination of benefits, subrogation, audits, health promotion, disease management and prevention programs and other uses stated specifically in the enrollment application. By signing the application form, the Enrollee also agreed and consented to the recording and/or monitoring of any telephone conversation between the Enrollee and the Contractor, on behalf of the State.

- Enrollees have the right to approve the release of information for non-routine uses of data. In certain circumstances, the Contractor, on behalf of the State, may obtain a specific release form before information is disclosed.

- For Enrollees unable to give consent, the Contractor, on behalf of the State, will obtain a copy of the guardianship papers or power of attorney before releasing confidential information to the Enrollee's representative.

- Enrollees have the right to access their medical records and to request that we restrict others access to their confidential information.

- The Contractor, on behalf of the State, takes reasonable precautions to protect Enrollee information and maintain privacy in all settings. Contracts with practitioners and providers explicitly state expectations about the confidentiality of Enrollee information and records.

- The Contractor, on behalf of the State, may provide certain information, upon request, to employers or their representatives without specific consent. In certain circumstances, the Contractor, on behalf of the State, may request that the Enrollee sign a specific release form before information is disclosed. If information is released, the Contractor advises the State that it must be kept confidential to the extent necessary or as otherwise provided by law, and that it should not be used for unlawful purposes.

Also note that any person or entity having information about an illness or injury for which benefits are claimed may give the Contractor or anyone acting on the Contractor's and/or the State's behalf any information about the illness or injury. The Contractor, on behalf of the State, may provide any person or entity any information about an illness or injury upon its request, if it is providing similar benefits. Benefits will not be provided where sufficient information cannot be obtained to properly process a claim. The Enrollee waives any and all privileges with respect to such information.

The Contractor's Customer Service Area, on behalf of the State, may release information to the Enrollee or the Enrollee's Spouse concerning a claim for benefits, or the Enrollee's coverage under this Certificate. If the Enrollee does NOT want the Contractor, on behalf of the State, to release such information to anyone but the Enrollee, the Enrollee must notify the Contractor in writing. The Enrollee's Spouse or any dependent child over age 18 must also notify the Contractor in writing if they do not wish such information regarding their claims or coverage released to the Enrollee by Customer Service. However, the Explanation of Benefit forms will contain information on all claims for benefits under the Enrollee's coverage, and will be sent to the person in whose name the coverage is held (except as prohibited by law).

CONTRACTOR INFORMATION PRACTICES NOTICE

The purpose of this information practices notice is to provide a notice to Enrollees regarding the Contractor's standards for the collection, use, and disclosure of information gathered in connection with the Contractor's business activities.

- The Contractor may collect personal information about an Enrollee from persons or entities other than the Enrollee.
- The Contractor may disclose Enrollee information to persons or entities outside of the Contractor without Enrollee authorization in certain circumstances.
- An Enrollee has a right of access and correction with respect to all personal information collected by the Contractor.
- The Contractor takes reasonable precautions to protect Enrollee information in its possession, including the use of restricted computer access.

BLUECARD PROGRAM

When the Enrollee receives health care services outside the geographic area served by Anthem Blue Cross and Blue Shield and those services are administered through the BlueCard Program, the amount the Enrollee pays for Covered Charges will usually be calculated on the **lower** of:

- The provider's actual billed charges for the Enrollee's covered services, or
- The negotiated price passed on to Anthem by the Blue Cross and/or Blue Shield Plan within the area where services are received.

Often, this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that includes expected settlements and other non-claims transactions with a provider or with a discount from billed charges that reflects **average** expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

In addition, laws in certain states require Blue Cross and/or Blue Shield Plans to use a basis for calculating the Enrollee's payment for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. When the Enrollee receives covered services for health care in those states, the Enrollee's payment will be calculated using their statutory methods.

FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENTS, OR BILLINGS

CALL YOUR CUSTOMER SERVICE REPRESENTATIVES

BUSINESS HOURS ARE 8:00 A.M. to 5:00 P.M. CENTRAL TIME

FOR MEDICAL QUESTIONS

1-877-814-9709
TDD – 1-800-475-5462

FOR THE PRECERTIFICATION PROGRAM UNIT

1-877-814-4803

FOR QUESTIONS REGARDING THE PHARMACY NETWORK

1-800-494-1428

FOR QUESTIONS REGARDING DENTAL OR VISION

1-800-828-3677

CLAIMS MAILING ADDRESS
Anthem Insurance Companies, Inc.
PO Box 37010
Louisville, KY 40233-7010

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL

HOW CAN YOU FIND OUT IF YOUR PROVIDERS ARE PART OF THE BLUE ACCESS NETWORK?

Ask your physician or hospital if they are part of the Blue Access Network.

This booklet is for educational purposes only and it is not intended to serve as legal interpretation of benefits. Reasonable effort is made to have this booklet represent the intent of the plan language. However, the plan language stands alone and is not considered as supplemented or amended in any way by the explanations of examples included in this booklet.

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